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**THE LIFE WORLD OF THE OCCUPATIONAL THERAPIST :  
meaning and motive in an uncertain world**

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Thesis submitted for the degree of :

Doctor of Philosophy  
in the  
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## ABSTRACT

This thesis explores the life world of twelve occupational therapists. Interpretivist, phenomenological methodology has been employed to capture the central features of what it means to be an occupational therapist. Assumptions arising from phenomenological, social constructionist and hermeneutic theories underpin the methodology. Data gathered from nine in-depth interviews, three participant observations and personal reflection, were analysed in an attempt to understand the therapists' own view of their reality.

Four global themes emerged through analysing the findings both phenomenologically and reflexively : 1. Who am I?: The fraught search for an occupational therapy identity; 2. The mission to make a difference : Enacting the therapists' craft; 3. Negotiating the boundaries : The caring-power relationship; 4. Safe haven or battleground? : Collaboration and conflict within the team.

Analysis revealed that whilst the therapists' sense of professional identity is profoundly confused, these professionals are committed to holistic, person-centred values and sustained by a belief that occupational therapy promotes health-enhancing change. Therapists are challenged by caring-power relationships as they struggle to negotiate degrees of involvement and are damaged by pressures, abusive people and lack of professional recognition. Their sense of achievement when they make a difference helps them to regenerate themselves and they are 'healed' when valued in relationships with both patients/clients and team members. Throughout their various challenges, struggles and satisfactions, therapists are engaged in a search to find themselves and to cope in their uncertain world.

Whilst the findings largely confirm the existing literature, they also offer some challenges. Therapists' experience has been found to be more complex (intense, ambivalent and contradictory) in practice than the literature indicates. A discussion explores the implications of the research for professional practice. The thesis also critically examines the use and value of phenomenology and reflexivity as research methods.



# TABLE OF CONTENTS

	<b>Page</b>
<b>1 INTRODUCTION</b>	
1.1 Occupational therapy : purpose and practice	2
1.2 Challenges to professions in a changing world	6
1.3 Rationale for research	9
1.4 Research approach and organisation of thesis	10
<b>2 LITERATURE REVIEW</b>	
2.1 Introduction	13
2.2 Changing contexts	15
2.3 Topical issues in occupational therapy	20
2.4 The experience of 'doing' occupational therapy	38
2.5 Research aims	65
2.6 <i>Reflections</i> on doing the literature review	72
<b>3 METHODOLOGY</b>	
3.1 Introduction	76
3.2 Philosophical and methodological choices	77
3.3 Research design and method	113
3.4 <i>Reflections</i> on the journey towards a methodology	133
<b>4 ANALYSIS</b>	
4.1 Introduction	144
4.2 The experience of being an occupational therapist	145
4.2.1 Who am I? The fraught search for an occupational therapy identity	146
4.2.2 The mission to make a difference: enacting the therapist's craft	163
4.2.3 Negotiating the boundaries: the caring-power relationship	184
4.2.4 Safe haven or battleground? Collaboration and conflict within the team	201
4.2.5 Summary of sub-themes	217
4.3 Reflexive analysis	224
4.4 Summary : The life world of the occupational therapist	245
4.5 <i>Reflections</i> on the process of analysis	253
<b>5 DISCUSSION</b>	
5.1 Introduction	259
5.2 Themes related to the literature review	260
5.2.1 The occupational therapist's role identity	260
5.2.2 Caring-power relationships	273
5.2.3 Is there an 'occupational therapy life world'?	287
5.2.4 The socially constructed therapist?	292
5.3 Methodological evaluation	295
5.4 <i>Reflections</i> on the relevance and implications of my research	310
<b>6 CONCLUSION</b>	
6.1 The life world of the occupational therapist	319
6.2 The value and relevance of the research	325
<b>REFERENCES</b>	334



**LIST OF TABLES**

	page
1.1 Linking social and health care policy with changes in occupational therapy practice and education	17
3.1 Summary of three perspectives and their implications for my research	80
3.2 Three types of reflexivity	107
3.3 Summary of participants and their work experience and setting	114

**LIST OF FIGURES**

	page
3.1 Map of philosophical and methodological field	77
3.2 Theoretical perspectives and some associated qualitative methods	79



## ABBREVIATIONS

CPN-           Community psychiatric nurse

GP -           General practitioner

NHS -          National Health Service

OT -           Occupational therapy or occupational therapist



## **DEFINITIONS**

### **Life world**

The life world is the totality of experience that makes up a person - the person is to be seen in what the life world is. The life world of every individual can be understood to be made of the person's sense of themselves as being a body located in a particular time and space and having a particular identity as they engage in relationship with others. It comprises the web of interconnected meanings encountered which forms the backdrop to all action and interactions and, as such, the life world cannot be dissected into a number of separate variables.

### **Occupational therapist**

Occupational therapists are health care professionals who use activity therapeutically to promote health and to enable individuals to perform their daily living occupations to a satisfying, effective level.

Occupational therapists work with individuals impaired psychologically, socially and physically, helping them to rebuild their lives in ways which are meaningful to them.

### **Occupational therapy**

Occupational therapy is the treatment of people with physical and psychiatric illness or disability through specific selected occupation for the purpose of enabling individuals to reach their maximum level of function and independence in all aspects of life. The occupational therapist assesses the physical, psychological and social functions of the individual in a structured programme of activity to overcome disability. The activities selected related to the consumer's personal, social, cultural and economic needs and will reflect the environmental factors which govern his/her lifestyle. (College of Occupational Therapists 1990).



## **ACKNOWLEDGEMENTS**

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I must also express my appreciation to all my research participants for the gifts of their time and their stories. I hope they will feel I have reflected their experience with integrity.

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## PROLOGUE

"The participants speak and I record and selectively represent their voices. But to pretend that this is simply a dialogical construction of the facts of the case would be arrogant, exploitative and deceptive. I hear the voices in my ears, and I speak my words, conditioned by my place in historical social movement and by language and analytical resources available to me.

Hopefully, I compose my account with an open mind and revisionary attitude, abetted by a good set of records and transcripts and a well-tuned memory. But I "take license." I select, condense, juxtapose, underline, and worst of all, I recontextualize live worlds in analytical social language. Still, I am not the cold-blooded instrument of an error-free objective knowledge machine that mirrors social reality; but, an historical, social analytic composer, and what follows is neither Truth nor Fiction, but a composition."  
(Wexler 1992, p.2)



# 1. INTRODUCTION

"Occupational therapy can be one of the great ideas of 20<sup>th</sup> Century medicine" (Reilly 1962).

*I have been an occupational therapist for twenty years, practising as clinician, academic and manager. In all my different roles I have tussled with the nature of occupational therapy - its potential, its purpose, its practice. Whilst I remain committed to the values and aims of occupational therapy, I have also encountered the dilemmas and tensions of practice. The spirit and enthusiasm occupational therapists feel is well captured by Reilly in the above quotation - such beliefs help to sustain us when we experience the frustration and confusion which can also exist when we try to transform rhetoric into practice. In the real world, enthusiasm is tempered as values are compromised and pragmatism replaces ideals. In my practice I have fought to promote my vision of what occupational therapy can and should be, but often this vision does not survive reality. Is my vision inappropriate or should I continue to fight for it? Currently the very existence of the profession is under threat as it evolves in a changing, uncertain health care context. Is it worth saving? These were the dilemmas and questions which provided the initial impetus for my research.*

This introduction sketches the background to, and rationale for, my research. In sections 1.1 and 1.2, I describe the nature of current occupational therapy practice in a changing health care context and offer my reflections (*in italics*) on how the challenges of this practice impacted on me personally. Since the momentum for this research emerged out of confusions and dilemmas I experienced in practice, it seems important to document these links. A third section briefly summarises the rationale for my research while a final section outlines how I set about the research and how the findings are presented in this thesis. The style of this introduction is largely reflective. The specific literature related to both professional experience and methodology will be examined in following chapters.



## **1.1 OCCUPATIONAL THERAPY : PURPOSE AND PRACTICE**

Occupational therapists are health care professionals who use activity as a therapeutic tool both to promote health and to enable individuals to perform their daily living to a satisfying, effective level. Occupational therapists work with individuals impaired psychologically, socially and physically, helping individuals to rebuild their lives in ways which they regard as meaningful. The diversity of needs and problems encountered leads to a diversity of solutions and practice. Thus occupational therapists carry out a range of therapeutic interventions, from supplying a wheelchair or teaching a patient to bake a cake to engaging in psychotherapy.

The diversity of roles practised makes it difficult to describe occupational therapy precisely. Certain common aims and values can be identified but the exact nature of these core aims and values has been the subject of hot debate within the profession over the years. However, the following five elements reflect a reasonable consensus:

- 1) Occupational therapists focus on occupational performance and are centrally concerned with how individuals function in their daily occupations of work, leisure and domestic/personal care activities.
- 2) Occupational therapists believe in the importance of participation and of being active in order to learn, develop skills and maintain functioning.
- 3) Occupational therapists believe in the therapeutic potential of (purposeful and meaningful) activities to promote health and well being.



- 4) Occupational therapists value patients/clients as unique individuals who have particular skills, needs, problems and motives arising out of their particular social and cultural background.
- 5) Occupational therapists aim to take a holistic, client-centred approach to practice, where the collaborative relationship between client and therapist is stressed. (Finlay 1997a)

In theory, the therapist is concerned to enable individuals to achieve a satisfactory life style and improve the quality of their life. The patients/clients themselves should identify what constitutes that satisfaction and quality. In practice, treatment is usually negotiated between the therapist, patient/client and treatment team, and this negotiation takes place within wider political-economic and health care constraints. Further, professional values are operationalised in diverse ways depending on the treatment context. When working with people who are physically impaired the occupational therapist will often focus on independence in personal care activities (e.g. getting in/out of a bath); with people who have mental health problems the therapist may work at broader social roles (such as coping with work and domestic activities); in hospital contexts the therapist will invariably be focused on remediating the effects of illness (e.g. improving range of movement or concentration); whilst in the community therapists will tend to work on broader, lifestyle issues (such as hobbies).

This diversity of practice contributes to a profound sense of confusion about the nature of occupational therapy, a relatively new profession. There has been much debate both about what occupational therapy is and what it should become in the future. One line of argument suggests occupational therapy should prioritise working with chronically impaired people and leave people with acute illnesses to other practitioners who



operate within medical models. A more radical line advocates that occupational therapists should withdraw from the hospital sector entirely and concentrate more broadly on being disability or 'life style' managers. Therapists also debate the nature of 'purposeful therapeutic activity'. Some argue that treatments such as counselling or splint making do not constitute therapeutic activity. Others reply that these be viewed as legitimate treatment tools because they enable meaningful occupation.

Many of these debates result from the fact that the role and practice of occupational therapy has gone through multiple transformations over its comparatively short life span. Occupational therapy began, within this century, as a profession which used crafts for therapy and diversion. Over the years, therapists have turned away from these beginnings to encompass 'daily living activities'. Now craft work is rarely seen (and is often actively resisted) as therapists endeavour to move away from traditional images of occupational therapists as 'basket weavers'.

In explaining these shifts, Creek (1997) argues there has been a shifting philosophical base. Occupational therapists emerged at the beginning of the century in a 'holistic era' where the profession was concerned to employ broad programmes of occupation, believing in the capacity of humans to achieve health through what they do. After the second world war, the profession entered a 'reductionist era' where the need to gain scientific credibility resulted in greater use of the medical model and prescriptive rehabilitation techniques. The 1980's saw an 'era of synthesis' where holistic approaches underwent a revival and the profession sought to reassert the values of occupation within the broader life roles of individuals.



*I have personally experienced, and grappled with these changes over my twenty years as an occupational therapist.*

*As a clinician I have experienced the sheer frustration of working within traditional medical model systems where the focus was on mental illness and reducing symptoms rather than on promoting mental health. Patients were patients - de-humanised, institutionalised, deprived of choices and control, encouraged to believe in the authority of the doctor and the expertise of the professionals involved. I resisted these messages, but I was also part of them; in a sense I colluded with them. How do occupational therapists like myself manage the contradictions between our holistic values and our more reductionist practice?*

*As a manager, I have felt confusion about the nature of the occupational therapy role and have questioned our priorities. I have also seen others' confusion and have had to battle, constantly, to promote our role and profession. I have experienced the disappointment and stress of dealing with wider treatment teams whose members routinely dismissed occupational therapy and did not value what we were offering. Ironically, some team members dismissed our contribution because they believed the negative stereotypes of us as 'basket makers', whilst others dismissed us because we no longer offered diversional services. It felt like we could never be valued.*

*At the time I found some resolution of these dilemmas within the literature of occupational therapy. I saw theory as the way to strengthen our purpose, improve our practice and unite a fragmented profession. Throughout my career I have fought to bring theory into practice, but many therapists have resisted these moves. So, I question myself - have I been right?*

*As an academic I have argued the need to embrace occupational therapy theory and have felt frustrated by the continuing practice of using an 'alien' medical model approach. Yet I can also understand the tensions of trying to operate within traditional hierarchical systems where a more holistic input is not valued. I have tussled with the dilemma of what to teach occupational therapy students. For instance, I have worried that I teach students that occupational therapists ignore diagnosis, whilst part of me wondered if that was really true. Have I done my students a disservice by advising them to resist diagnosis when they have to operate within the 'real world' which uses a medical model?*

*These questions, dilemmas and tensions gave impetus to my research. What is the nature of our role? What is our current practice and what should we become in the future? ...*



## 1.2 CHALLENGES TO THE PROFESSIONS IN A CHANGING WORLD

Changes in the broader economic, political and health care context over this last century have had profound effects on all the health care professions. Specifically, the last decade has witnessed significant changes with the rise of the new right market ideology which has resulted in considerable structural reorganisation of health care. A number of different challenges have confronted health care professionals - challenges which, arguably, threaten their very existence :

- 1) New imperatives to demonstrate quality and effectiveness have resulted in professionals being asked to prove their 'worth'. Pressure is on professionals to research; to substantiate their interventions; to develop 'evidence based practice'. New standards have had to be developed and professionals have scrabbled, reluctantly, to learn about and implement clinical audit. In this era of greater accountability, therapists are having to be more specific about aims and outcomes of treatment and to evaluate services in more systematic ways.
- 2) Extensive internal staffing reorganisation has taken place alongside the broader health service changes, such as the rise of Trusts. In particular, there has been a breaking down of professional hierarchical structures; for instance, occupational therapists may now be managed by a member of another professional group. These reorganisations have led to a loss of both supervision/support and the traditional promotional structure. On the positive side, new team work opportunities have emerged as therapists have been obliged to collaborate more and to learn from others. Further, new opportunities have opened up for practitioners to be promoted through the general management hierarchy.



- 3) Similarly, the therapists' role in treatment teams has continued to evolve, particularly with the growth of new community practice. Increasingly, therapists have found themselves operating as single, isolated professionals within multi-disciplinary teams. Lacking profession-specific support, they have lost a sense of their unique contribution. The move towards role blurring and generic workers has mushroomed, further threatening the status of particular professional groups. With these challenges, however, have come new learning opportunities and, arguably more client-centred, as opposed to profession-centred, care.
- 4) The push towards cost effectiveness has led to new pressures where professionals compete with each other for jobs. There is the push towards 'downsizing' - getting work carried out by fewer professionals (such as one key worker), or by practitioners who can be hired more cheaply. Professionals have been forced to try to communicate the value of their service as clearly and as vigorously as possible in order to justify their existence.
- 5) In the context of inter-professional competition, professionals have sought to become more organised; to gain more status and qualifications; and to obtain academic respectability. These moves to 'professionalize' have been reflected in the way professional educational institutions have been converted from offering vocational diploma courses to more academic research and degree programmes.
- 6) Finally the rise of consumer orientations has forced professionals to re-evaluate what they can offer and to become more responsive to consumer demands. Professionals can no longer rest on easy assumptions of the 'professional as expert' and instead are being increasingly required to consult with patients/clients and their carers. However, collaboration requires more time, and such imperatives sit uneasily alongside pressures to treat more people, more quickly.



*In 1992 I resigned from my position as Head Occupational Therapist (Psychiatry) at St. James's University Hospital in Leeds. I was frustrated with the system which I saw as pursuing inappropriate values and irrational policies. I was concerned about the pressures that professionals - in particular my staff - were under in their struggle to cope with the pace of change. I was worried about what was happening to the care of patients/clients with the 'dismantling' of the health service.*

*As a manager I was caught between imposing and resisting the new rhetoric. It seemed as though everywhere I looked change was taking place and it was out of control. Every week there were new policies, new directives, new jargon to learn. Every week services were being dismantled and restructured. We groped about in a fog of uncertainty, confronting disturbing new questions : How would the new Trusts impact on our work? How were we to implement all the new quality assurance measures? The only thing we could predict was a continually reducing budget. "No money" for my collapsing roof to be fixed. "No money" for essential staff development. Yet there was money to build new consulting rooms for the doctors, to design new logos and stationery for the hospital, to employ new managers. There was even money to upgrade my post to take me away from my staff who desperately needed professional support and guidance.*

*As a clinician I also experienced the pressure first hand. There was pressure to work harder and to treat more people, more quickly. There was increasing pressure to define and justify our role, prove our worth - and if we couldn't, we would be left behind. On the one hand there was a demand to reaffirm our professional worth and status, on the other, the professional support structure was disappearing and there was pressure to relinquish professional identity towards working better in the team. We had the dual challenge of holding on to our knowledge/skill base (which we valued) whilst developing new ways of working. All this was taking place in a context where each professional group was in direct competition with another. The rhetoric of team work sat uncomfortably alongside the reality of keeping our jobs only at the expense of others.*

*As an academic I grew concerned that we were not adequately preparing students to cope in this new, changing and pressured world. I was also concerned that students were coming out into the field without a clear sense of their own professional identity. How were they to argue their case? How could they compete? How could they justify their practice and prove their worth when they did not even know what it was they offered? The whole profession of occupational therapy seemed to be in jeopardy. Would (and should) occupational therapy survive?*

*In this time of uncertainty, it seemed important to hear and document the experience of the professionals involved and learn how they were coping. The threats were clear, but were there also opportunities that could be grasped? Given the context in which professions were being dismantled, it seemed essential to take the less favoured route of profession-specific research and go deeper into the issues, before it was too late.*



### 1.3 RATIONALE FOR RESEARCH

In summary, health care professionals are under considerable pressure in a changing world where their present is insecure and their future uncertain. In referring to change and the insecurities of the post-modern world, Frosh (1991) states that, "finding our uncertain way through these uncertainties is a prime task for contemporary existence" (cited in Thomas 1996, p. 327). Given this task to 'find our way', it seems important to hear and document the experience of professionals currently grappling with the pressures. Specifically, I am concerned with the nature of the occupational therapist's experience and to ask how they are coping. Some of the threats are clear, but are there others, and are there also opportunities that could be grasped?

In the context of dismantling professional structures as we know them, it seems relevant to undertake some profession-specific research. Although this is a less favoured route given the climate of evidence based, client-centred, collaborative practice, it seems essential to go deeper into profession-centred issues before it is too late.

My research aims to investigate what it means to be an occupational therapist at the close of the twentieth century. What is the therapist's day-to-day experience? How large a gap is there between rhetoric and practice? What gives these particular professionals meaning and satisfaction? What motivates and sustains them in the midst of all the pressures, confusions and uncertainties? Do they identify with their professional group? How do they understand and enact occupational therapy in the context of marked role ambiguity and external challenges?



## 1.4 RESEARCH APPROACH AND ORGANISATION OF THESIS

In this thesis, I have sought to capture the 'real world' experience of how professionals are grappling with the demands of their changing and uncertain world. As an occupational therapist myself, I had a particular interest in investigating the nature of our current practice so I chose to investigate **'the life-world of the occupational therapist'**. The life world, a concept arising primarily from a phenomenological tradition, is the world of objects around us as we perceive them and our experience of our body, self and relationships. The idea of life world is that we exist in a day-to-day world that is filled with complex meanings which form the backdrop of our everyday actions and interactions.

In order to gain this understanding of the life world I have pursued an entirely qualitative research path. Specifically, I have chosen to adopt a phenomenological research approach (explained in chapter 3 on methodology) which aims to describe individuals' own meanings and perceptions of their life world, rather than produce an objective, factual account of the current state of occupational therapy. The phenomenological approach rests on the attempted suspension of presuppositions and prior understandings in order to enter into the world of the unique individual being studied. To this end, I embarked on my study not with the conventional literature search (which I believed would colour my subsequent research) but with direct data collection. I invited a number of occupational therapists to tell their own story in their own words, using interview and participant observation as my methods of research (see section 3.3). My aim here was to obtain a rich, personally engaged insider account in tune with phenomenological principles.



Having obtained my data, I carried out an in-depth interpretative analysis (see chapter 4). In the process there emerged four over-arching global themes which became the core of my thesis (see section 4.2). Taken as a whole they offer a glimpse into the life world of the occupational therapist as presented by my small group of participants (see section 4.4).

After analysing my themes I undertook a systematic literature review which aimed to map key occupational therapy debates and current professional preoccupations.

However, in presenting this thesis, I have placed this review prior to the analysis in order to provide an orientation for readers enabling them to locate my research in the broader context (see chapter 2). For this reason, I also adopt the standard approach of ending the literature review with a detailed account of my research aims (see section 2.5).

Important commonalities between my analysis and the literature review have emerged - not surprisingly if the existing literature does indeed reflect something of the life world.

In chapter 5, I explore these areas of convergence, but also identify points of divergence suggested by my research. This discussion chapter also engages in a critical evaluation of my findings, method and methodology (see section 5.3).

In adopting a phenomenological approach, I recognise that my research has involved a dynamic process in which outcomes emerge out of the specific relationship between myself and the research participants. Access to the therapists' inner worlds is both dependent on, and complicated by, my own assumptions, conceptions and interpretations (Smith, Flowers and Osborn 1997). For these reasons, a significant



portion of this thesis is devoted to exploring the central role that I, the researcher, have played in its construction. Towards this end, I offer two additional types of analysis :

- i. a reflexive analysis which acts as a supplement to the thematic analysis (see section 4.3);
- ii. a *reflections* section (found at the end of each chapter).

Reflexive analysis involves a process of systematic meta-analysis where I, the researcher, aim to be critically self aware through analysing how I have influenced, and been influenced by, the research. This reflexive analysis aims to examine the basis of my interpretations and to capture how subjective and inter-subjective elements have impinged on the research.

The *reflections* sections comprise my thoughts about the research where I document my personal reactions and evaluations. Taken as a whole these *reflections* sections combine to offer a critical commentary on my process of engaging in the research. As such, readers may wish to approach this thesis by uncoupling the *reflections* from other sections and focusing on either one or the other. Alternatively, readers may wish to read these *reflections* in combination with the methodology chapter and the evaluation towards exploring the use of phenomenological methodology.

My aim in presenting these two personal dimensions of reflexivity and *reflection*, is to make the entire research process transparent. Of course, exposing my own inadequacies and the flaws or limitations of research carries risks, but I believe it is the best way to demonstrate the degree to which my work is authentic and trustworthy. I envisage that these sections will help readers assess the quality of my judgements and determine the degree of confidence they wish to place in this thesis.



## **2. LITERATURE REVIEW**

### **2.1 INTRODUCTION**

My literature search unearthed no research explicitly on the life world of occupational therapists, so I have had to cast a slightly broader net. The following literature review attempts to map the range of research that does exist on occupational therapy practice and experience. I have tried to include what little phenomenological research has been undertaken in occupational therapy, as well as drawing more generally on the broader occupational therapy literature. I have operated on the assumption that the findings emerging in the literature reflect the actual experience of clinicians.

A second assumption is that occupational therapists share a life world with other health professionals. To this end, I have made some use of the considerably wider, deeper pool of health care literature. Throughout, I have attempted to maintain a selective focus on the occupational therapy practice issues which seemed most relevant to my research : I have homed in on applied health care research rather than the wider literature related to psychology (e.g. Goffman 1968), sociology (e.g. Foucault 1982) or work on professionalism (e.g. Freidson 1994). Also, I have given primacy to the literature which drew on phenomenology rather than other methods such as social constructionist discourse analysis.

Section 2.2 analyses the impact of broader philosophical and political-economic developments on occupational therapy. Then, the challenges professionals as a



whole, and occupational therapists specifically, face in the changing health care context is discussed.

Section 2.3 maps the key topical issues in occupational therapy. The issues featuring strongly in much of the research of the past decade would appear to mirror the profession's current preoccupations. The five topical issues identified are :

- 'articulating the angst' : confusions about the occupational therapy role
- battle for a theoretical base : a profession in crisis?
- one animal or several? : diverse roles and practices
- occupational therapy values : the struggle to be holistic
- mapping occupational therapists' reasoning

Section 2.4 focuses on the experience of 'doing' occupational therapy by touching on a range of research into experiences of health care professionals. Three key themes related to practice are explored :

- satisfying and dissatisfying dimensions of practice
- relationships with patients/clients : caring or power?
- therapists under siege : the pressures of the work context.

Section 2.5 explains how the preceding review provides the empirical/methodological context and rationale for my research.

Section 2.6 presents an account of my *reflections* on doing the literature review. In it I discuss both my experience of doing the review and my subjective evaluation of the outcome.



## 2.2 CHANGING CONTEXTS

Changes in occupational therapy practice emerge out of the wider socio-economic, political, cultural, scientific and philosophical revolutions which have taken place in our society over the last century (Hagedorn 1995).

Occupational therapy grew out of the 'moral treatment' movement and the humanitarian philosophies of the 18<sup>th</sup> and 19<sup>th</sup> Centuries which held that society had a moral obligation to help less fortunate members. Participation in productive activity was seen as inherently 'good' for people, in the sense of being morally superior to idleness and producing desirable outcomes for society. Increasingly patients were treated as rational human beings who could be induced to adopt orderly habits and participate in beneficial labour and exercise. The Arts and Crafts movement also stressed the necessity of creative activity to counteract the dehumanisation of work that occurred in the course of the industrial revolution (Kielhofner 1992, Hagedorn 1995).

The profession of occupational therapy came into being on the basis of the philosophy and work of Adolph Meyer. Meyer believed that humans needed a balance of daily activities in their schedule of work, play and rest. He conceived man as "an organism that maintains and balances itself in the world of reality and actuality by being in active life" (Meyer 1922, cited in Mayers 1996).

After World War II, the demand for rehabilitation spurred the growth and evolution of the profession, with handicrafts employed both as a source of diversion and as a



way of re-establishing physical skills and movement. Extensive use of handicrafts continued through the 1950s and 1960s in tandem with a medical model orientation. In the 1970s medical and scientific advances, and the growth of community care, caused therapists to turn away from crafts and favour more technical and scientific approaches to rehabilitation. The 1980s and 1990s saw a return to valuing the creative and curative potential of occupation with therapists seeking to develop their own philosophical, theoretical and research base (for instance, adopting ideas emerging from the field of 'occupational science') rather than simply borrowing from other professions and sciences.

These changing faces of occupational therapy practice were a part of a larger process of 'professionalisation' taking place in different ways throughout the health professions as each sought to develop its knowledge base in order to gain greater credibility and status (Hugman 1991). These moves to professionalise are reflected in the way training and education have developed. In the 1980s the push towards increasingly academic and theoretical approaches to practice occurred alongside a move into higher education. By the early 1990s occupational therapy training had achieved full graduate status and therapists then worked to obtain higher qualifications. Both practitioners and educators have come to recognise the importance of developing a research base and growing numbers of therapists (in common with other health care professionals) are now engaged in research. (See Table 1.1).



<i><b>Decade</b></i>	<i><b>Social policy and health care context</b></i>	<i><b>Occupational therapy practice</b></i>	<i><b>Occupational therapy education</b></i>
1950s-1960s	Post-war boom; new NHS and the growth of new hospitals and advances in treatments.	Therapy strongly influenced by a medical model; handicrafts used extensively; some industrial therapy and bio-mechanical rehabilitation.	Three year nationally standardised occupational therapy diploma course. Medical sciences taught in traditional ways; much emphasis on the learning of crafts.
1970s-1980s	Reorganisations of health and social care including growth of community sector.	Adverse reaction to craft work in favour of rehabilitation of skills and functioning. Physical practice focuses on activities of daily living; in psycho-social practice, industrial therapy gives way to group work.	Gradual move into higher education and phasing out of national examinations; Increasingly academic, theoretical focus though some craft work remains.
1990s	Restructuring of health authorities; growth of purchaser/provider systems; growth of managerial systems and consumer orientations.	Development of community orientated work and one-to-one counselling; growth of interest in occupational performance models and profession specific theory/research.	Development of new degree and higher degree courses as all courses located in the university sector (i.e. profession has now achieved full graduate status).

Table 1.1 Linking social and health care policy with changes in occupational therapy practice and education.

The 1990s have witnessed particularly dramatic changes in the health care context.

The rise of the 'new right' liberal market ideology resulted in major economic and structural reorganisation of health care delivery which, in turn, had a profound impact on professionals. First of all, the move towards a purchaser-provider split and the rise of the private, voluntary and community sectors transformed health care services. Second, as the State became a regulator rather than a provider there came an attack on 'elitist' professionals and claims that a business management approach would be more efficient. At the same time, free market ideas about 'profit', productive efficiency, cost effectiveness and value for money replaced traditional notions of 'service'. Finally, escalating costs, new technologies, increasingly



expensive treatments, shifting demographics, rising consumer demands and other pressures have forced health service planners and providers into tough decisions about priorities and rationing (Jones 1998).

As part of the restructuring, we have seen the closure of hospitals in favour of new community services and the development of a business contract culture, G.P. fund-holding, and hospital trusts. These changes have had fundamental impact on health professional practice in a number of ways. Firstly, the rise of new community services has resulted in new forms of professional practice where the blurring of professional roles within the team has occurred alongside increasing team and inter-agency collaboration (Finlay, forthcoming). Secondly, market considerations have resulted in continuing pressures on professionals to demonstrate quality and effectiveness in the context of inter-professional competition. Thirdly, the business culture has resulted in a rise of managerialism which is replacing long established forms of professional accountability (Jones 1998).

All of these trends have challenged professionals' autonomy, status and authority. This erosion of power has been both reflected in, and spearheaded by, a range of social and government policies. For instance, Davies (1998b) argues that proposed changes to statutory regulation for the health professionals (such as the current proposals for the Professions Supplementary to Medicine Act) represent a withdrawal of trust in the professions which was begun by the Conservative government in the 1980s. One profound shift, suggested by Davies, is how statutory self-regulation of professions seems set to be replaced by a different model of statutory professional regulation.



In a different vein, several writers suggest that recent reforms in the public sector have involved changing professional identities. In particular, with the rise of managerialism, professional and management roles are seen as becoming increasingly blurred (Exworthy and Halford 1999). Halford and Leonard (1999) suggest that these developments have involved what amounts to a revolution in organisational behaviour and self-image. They argue that accomplishment of such change in any organisation depends, in part, on the way individuals embody new practices and identify with new values.

As the millennium approaches, New Labour appears to be placing more emphasis on partnership and collaboration across agencies. In an increasingly complex health market (Jones 1998), professionals are being challenged to be clear about their role and contribution whilst shifting the focus from profession-centred to client-centred care. As Jones and Tucker note, "the continuing advancement of teamwork means that in many instances alternative patterns for work are being created, that will require individuals and groups to radically reassess their occupational priorities and practices" (Jones and Tucker, forthcoming).



## 2.3 TOPICAL ISSUES IN OCCUPATIONAL THERAPY

### **Confusions about the occupational therapy role - articulating the angst**

The literature is replete with discussion on the nature of the occupational therapy role. Much angst has been expressed about feeling misunderstood, undervalued and also negatively stereotyped by traditional images. Periodically such angst has even led to calls to change the profession's name. Beyond this, occupational therapists are exhorted to be clear about their role and justify their profession but at the same time they express frustration at constantly having to do so. Lacking a clear definition of occupational therapy, they find it difficult to articulate what they do, nor can they specify with any certainty their role in terms of day-to-day practice in any field. Furthermore, therapists cannot even agree on the meaning of such key professional concepts as 'occupation' (Creek 1992).

Many writers have commented on occupational therapists' role confusions. In 1977, Shannon noted that there was no agreement on what occupational therapy was nor what it ought to be. More recently, Lycett (1991) found that most occupational therapists experienced difficulties in defining and explaining their role. Thorner goes further, stating that even "many experienced therapists struggle to give an adequate, concise and informative response to a request to define their own profession" (1991, p.222). Contrasting occupational therapists with other health care professionals such as physiotherapists, Lloyd-Smith (1994) remarked that occupational therapy practitioners struggled to understand their roles.



Other authors focus on the potentially destructive consequences of not being able to define the profession adequately. Two decades ago, Clark (1979) warned occupational therapists that other professions were usurping their jobs because they had been unable to clearly define their role and theoretical/research base. McAvoy (1992) audited patients' awareness of occupational therapy, recognising how public misperceptions caused practitioners much frustration. A survey of patients who had been treated over a last three month period found that 32% of clients in the community and 13% in the clinic were not even aware that they had received occupational therapy. Such a finding poses questions about the value of occupational therapy interventions if they cannot be recognised as specific treatment.

Blom-Cooper's (1989) Independent Commission report, entitled 'An Emerging Profession', emphasised how occupational therapy was currently a "submerged profession". Picking up this theme, Hagedorn argues :

Our professional visibility is being camouflaged by our continuing difficulty in expressing the processes and purposes of occupational therapy. There is still a gap between our professional perceptions of the scope and potential of our interventions, and the distorted image that others perceive (1995, p.324).

She goes on to implore occupational therapists to do away with pointless, anxious introspection about their role and calls to change their name. Instead, she argues, practitioners should question the way they present and take some responsibility for perpetuating negative images.

The literature is full of occupational therapists protesting against the persistently negative images and misconceptions about the purpose and practice of the profession (see for example, Dunkin and Goble 1982). In particular, therapists are seen to



struggle against traditional images of basket making and entertainment - of providing diversion instead of active treatment. Such myths endure in the minds of the public, patients/clients and other professionals.

Whilst a number of studies (e.g. Stockwell et al 1987) indicate that patients/clients value occupational therapy, it appears they also have a number of misconceptions.

Harries and Caan (1994) demonstrated how patients view occupational therapy as merely something to keep them busy or even to give the ward staff a break.

Significantly, 82% of the psychiatric patients surveyed felt that entertainment was part of the occupational therapy role - a point on which all of the therapists surveyed disagreed. Polemi-Walker, Wilson and Jewens (1992), studying practice in the US, found patients similarly valued the diversional element of occupational therapy.

Other studies indicate professionals vary in their understandings of occupational therapy. One study by Jenkins and Brotherton (1995) revealed marked variations in views about it amongst both occupational therapy staff and other team members.

Harries and Caan (1994) showed how ward staff on a psychiatric unit, like the patients, tended to see occupational therapy in terms of entertainment, while Smith (1986) found doctors had a limited understanding of it. Chakravorty (1993), in a survey of senior doctors found 70% of hospital consultants and 50% of GPs lacked awareness of what services occupational therapy supplied.

Arguably, a degree of confusion about role definition is to be found throughout the healthcare professions, particularly with the advent of team collaboration and role blurring. Kaur et al (1996) surveyed 89 multi-disciplinary team members in mental health and solicited their views about occupational therapy. They found that each



discipline saw an overlap between its own work and that of occupational therapists, indicating a degree of role blurring. The study also revealed that while others could recognise key occupational therapy functions, they were not confident that they really understood the occupational therapy role and, more significantly in terms of practice, did not apply their knowledge in referral patterns.

This persistent lack of understanding from every direction seems to have damaged occupational therapists' professional self esteem. Blom-Cooper's 1989 Independent Commission study, noting this problem, exhorted every occupational therapist to seek ways to develop self esteem. In partial explanation of why occupational therapists should suffer a poor professional self image, the Commission suggested that practitioners were sometimes seen as performing unskilled common-sense tasks which did not merit the prestige accorded to doctors and others.

Other writers suggest the problem of poor professional esteem is linked to the absence of a secure conceptual-theoretical base - one that encompasses core occupational therapy ideas and is not simply borrowed from other professions. In 1980, Tigges called for both educators and clinicians to develop a scientific paradigm and a body of knowledge or else the profession might not survive.

Kielhofner (1992, 1995), amongst others, has suggested that occupational therapists lack a common core to bind their diverse concepts and rich variety of practice. He makes the point that all too frequently practitioners resort to defining themselves around activity media (such as groupwork) or single techniques (e.g. orthotics). Without a central organising philosophical base, occupational therapy practice is in danger of being ambiguous and incoherent.



As Creek and Ormston point out : “Through three decades of professional publication, the same writing has appeared on different walls : warnings that we need to clarify our role and become more proficient in expressing our unique practices; and to establish a firmer scientific theoretical base” (1996, p.7). Golledge (1998) picks up this theme, arguing that occupational therapists need to clarify their unique contribution to the health care team if the profession is to survive in the current market-driven political and economic context. She exhorts occupational therapists to reflect on their professional practice and unite under the banner of 'occupation' as a unifying theoretical concept.

Authors such as Creek and Ormston (1996) and Golledge (1998) tend to assert their sense of current practice and their views of what occupational therapy should be in the future. What is missing from these types of analysis is a careful investigation into how the therapists themselves actually experience practice. Are therapists concerned about not having a firm theoretical base? Do they, in fact, believe in occupation as a unifying concept?

### **Battle for a theoretical base : a profession in crisis?**

Kielhofner and Burke (1977), in reference to Kuhn's (1970) work, presented occupational therapists' confusions as a 'profession in crisis'. They saw the confusion as the result of shifting paradigms : occupational therapy had passed through two paradigms and was now engaged in a third. The first paradigm,



emerging at the turn of the century, involved principles of moral treatment where occupation was seen as central to human life. The second paradigm, lasting into the 1970s, was reductionistic and mechanistic as occupational therapy became subverted by the medical model and the application of technology. By the end of the 1970s, this was being rejected and Kielhofner and Burke foresaw a shift to a new paradigm - one that was more holistic and occupational in focus. They argued that by returning to a more holistic paradigm and by embracing new theory related to human occupations, occupational therapists would clarify their role and once again unite as a profession.

In 1992 Kielhofner updated his work, exploring the concept of paradigms in some depth. In his definition, the occupational therapy paradigm, or 'cultural core', comprises : a) core assumptions (what therapists believe); b) a focal viewpoint (what therapists know); and c) values (deeply held convictions). He saw therapists as having returned to more holistic values but with a more sophisticated appreciation of the links between humans, occupations, their meanings and the environment.

Mocellin (1992) criticised Kielhofner's use of Kuhnian notions, focusing instead on the evolutionary development of a relatively new profession. In his view, occupational therapy is too flexible and adaptable in its beliefs and theories to adhere to the 'tunnel vision' of a paradigm conflict. In the United Kingdom, Hagedorn (1995) assumed the middle ground, viewing the occupational therapy core as consisting of definable philosophy and practice which is organic in nature. She suggested that this core was imperfectly described from the outset leading to uncertainties concerning its boundaries. And while accepting that there had been



theoretical oscillation as the profession has moved away from medical and scientific models, she viewed this as a “paradigm wobble” rather than a ‘shift’.

Steering the debate away from philosophy towards articulating occupational therapy’s theoretical commitments, Mosey (1985) argued that any profession can take one of two approaches to its identity : it can either be monistic (and adopt a unified stance) or pluralistic (and embrace the idea that no one principle can define a profession). She took issue with efforts to unify occupational therapy under a single theoretical umbrella, such as the model of human occupation (Kielhofner 1995); so diverse is the practice of this profession, she suggested, that it cannot be reduced to one unifying element. Instead, she favoured a pluralistic identity to give therapists freedom to grow and progress unencumbered by tradition and ideology.

In a similar vein, a number of scholars (Richards 1995, Kelly 1995, Creek 1995) have situated the confusions of occupational therapists within the context of our post-modern world. Here, occupational therapy is viewed as broad based, eclectic in approach and not allying itself to any one universal truth. Webber (1995), in a more specific argument, linked occupational therapy with postmodernism in two ways :

- 1) the emphasis on process and the move away from scientific objectivity means that therapists’ own subjective interpretations and intuitions are increasingly valued;
- 2) therapists and clients plan treatment based on individual and local needs. Viewing occupational therapy in terms of post-modern philosophy provides an interesting explanation for the confusion and lack of unity amongst practitioners.

Alternatively, the confusion over the role and aims of their profession may simply reflect the lack among occupational therapists of sufficient theoretical grounding.



Research by Mayers (1996) demonstrated that practitioners were not aware of and did not use any explicit occupational therapy models. Others (Feaver and Creek 1993, Finlay 1997a) have picked up this theme, urging occupational therapists to locate their practice in theory rather than unreflective, pragmatic reasoning.

The relevance of this somewhat esoteric debate lies in its exposure of how the nature of core occupational therapy ideas continues to be contested. The use of multiple theories or, alternatively, the absence of any theory at all, goes some way to explain why practising therapists experience difficulties in describing their role. The notion that the profession is in the midst of changing philosophies further explains role confusion. Divergence in the practice of different occupational therapists (physical/mental health; hospital/community areas) can be seen in terms of their attachment to different paradigms.

### **One animal or several? : Diverse roles and practice**

One reason why occupational therapists find difficulty in defining their profession is that the practice is so diverse. Practitioners can be involved in virtually any area, working with individuals impaired physically, psychologically and socially. They focus on complex and varied problems experienced by individuals in different social situations. They also adopt a wide variety of roles depending on whether treatment is taking place in physical versus mental health settings or in hospital or community contexts.



Diversity is especially marked when one considers physical occupational therapy on the one hand and psycho-social on the other. Although occupational therapists may be joined by a common philosophy and aims (Mayers 1990), the differences between physical and psychiatric work are well acknowledged within the profession. The existence of negative stereotyping of the 'other' (the view, for example, that 'physical occupational therapists are rigid/mechanical' or, on the other hand, that 'psychiatric occupational therapists are waffley/creative') attests to this.

Creek and Ormston (1996) suggested that recent changes in health care have created even greater divergence in the practice of physical and mental health therapists. They argue that the profession's holistic, rehabilitative principles are especially appropriate for mental health settings, whilst physical medicine is becoming increasingly pragmatic, task orientated and reductionist. Mental health therapists are seen to be operating increasingly within the community where social and health needs are not separated - and occupational therapists' eclectic, flexible approach is highly valued. In physical hospital settings, however, occupational therapy's broad base is not valued. Occupational therapists are expected to focus on assessing activities of daily living, with the overriding goal being quick discharge to release expensive beds.

Such a divergence would suggest physical therapists are returning to earlier reductionist paradigms and denying current professional values. Moreover, it fuels the debate about whether or not occupational therapists and physiotherapists might join together as a single profession and become generic therapists. The movement towards generic therapists has been actively resisted by many occupational therapists



(particularly in mental health), but others can see physical occupational therapists relinquishing claims to an occupational therapy identity as a logical progression.

A different division occurs between hospital and community therapists. This divergence has also been well documented. For example, Pimental and Ryan (1996) compared the role of occupational therapists working with multiply handicapped clients in hospital versus community contexts. Their results showed a distinct difference, with remedial activities being the focus in hospital and functional activities taking precedence in the community. They also noted a shift in community practitioners away from being therapist to being enabling consultants.

Taking a different line, Feaver and Creek pointed out how in hospital institutions (psychiatric or physical), occupational therapists tend to work within the dominant ideology of a medical model. This dictates the orientation for therapy, with therapists obliged to “carve a niche for themselves within a conceptual framework incongruent with their own” (1993, p.59). Feaver and Creek suggested that this lack of professional autonomy often results in occupational therapists providing a ‘technical’ service (for instance orthopaedic occupational therapists being ‘discharge technicians’).

Whilst the new move into the community provides opportunities for therapists to practice more holistically, this move has not been without problems. Therapists, especially on the mental health side, have tended to opt for team collaboration. As Feaver and Creek note : “Working in a multidisciplinary way brings about the relaxing of professional boundaries, surrendering professional language and



theoretical orientations and joining together in the multiprofessional melting pot of therapies” (1993, p.60).

The differences between physical and mental health therapists, the reductionism of hospital occupational therapy, and the pluralism of community occupational therapy, indicate a continuing struggle within occupational therapy to maintain a sense of role boundaries. The diversity of practice raises questions about the extent to which it is possible to describe a common occupational therapy experience. However, the literature also emphasises that the profession can be united through its holistic, client-centred values.

### **Occupational therapy values : the struggle to be holistic**

The philosophical core of occupational therapy is humanistic, holistic and client-centred (Mayers 1990, Creek 1996, Hagedorn 1995). Occupational therapists aim to view and treat individuals as complex whole beings, attending to emotional, cognitive, social and physical aspects, rather than homing in on isolated parts (Finlay 1997a). As Christiansen and Baum express it, "Because of occupational therapy's focus on life performance, it is neither somatic, nor psychological, but concerned with the unity of body and mind in doing." (1991, p. 9) Patients and clients are seen as individuals with their own values, skills, problems, needs as well as a wider social and cultural heritage. The individual is seen "not as an object or thing to be manipulated, controlled or made to conform but as a unique individual whose very humanness entitles him to choices in determining his own destiny." (Yerxa 1967, p. 3).



Yerxa (1983) made it a point to contrast occupational therapists' holistic values with the more reductionist values of medicine, arguing that despite occupational therapists' proximity to the medical model, the profession remains ideologically separate.

Occupational therapists, for instance, require patients to participate actively in treatment whereas traditional medicine prefers a more passive patient relieved of responsibility. Also, occupational therapists value subjective understandings and so seek the patients' perceptions of their problems, whereas medicine values objectivity and the use of scientific diagnosis.

Other literature addresses a dilemma posed for some therapists who work within the medical model context. For instance, Phillips (1996) explored the emotional labour of nursing in terms of the tension of applying holistic health care in a society which holds biomedical paradigms in high regard. Similarly, Bamitt and Pomeroy (1995) pointed to a traditional conflict amongst health service professionals between the medical model and psychosocial, or humanistic, models. Other research denies such tensions. Adamson et al (1994) surveyed 378 occupational therapists in Australia and found that client-centred interaction, client responsibility and holistic attitudes towards health care were valued above any biomedical approach. Age and years of professional experience also yielded significant differences with the more experienced therapists tending to emphasise a humanistic approach.

Much of the wider health care literature reveals tensions between theory and practice, such as the move towards holism in theory versus the practical constraints of applying holistic health care. A number of researchers (Smith 1991, Strauss et al 1982, James 1989, 1992) note the attempt by health care professionals to adopt a



more person-centred approach to care, but say that this is frequently frustrated by instrumental and mechanical procedures. Engelhardt (1986) and others have identified the conflicts that arise when attempts are made to reconcile issues of cost containment with providing quality care. Fondiller et al (1990) picked up this point noting the challenge faced by therapists who seek to enact their holistic approach in the context of health care systems which do not support their priorities.

The shift to more mechanical practice is seen partly as a function of the realities of the work setting, where 'caring' is replaced by 'efficient' routines (for instance, swift discharges to release bed space). At a deeper level these realities are dictated by structural circumstances and power relationships. For instance, Hubbard (1991) suggested occupational therapists feel they have limited professional standing compared with physiotherapists - one explanation being that physiotherapy enjoys a higher status because its key concepts are more in tune with a medical model. Similarly, Phillips (1996) highlighted the contrast between the rhetoric of caring and attempts by health professionals to raise their standing by buying into more prestigious biomedical/scientific paradigms.

Others challenge the degree to which practice can ever be really holistic. Barker and Baldwin (1991) described how psychiatric nurses and social workers embrace the concept of treating the whole person. They went on to point to the reality of these clinicians' reductionist practice, suggesting that holism was 'romantic fiction'. Bamitt and Mayers (1993) also questioned whether holism is ever really practised. They recognised its emphasis in academic programmes but asked if it has any application in the field, given the realities of time and financial constraints. They also suggested that much occupational therapy is well organised but pragmatic, with little explicit



application of grand theory or frames of reference. Bamitt and Pomeroy (1995), however, argued that there is only an apparent conflict between science/reductionism and humanism/holism, and that these dimensions should be seen to exist on a continuum. Holism can only be aspired to within the team. Individual therapists may aim towards person-centred practice but pragmatic reductionism is to be expected (Finlay 1997b).

Overall, whilst there is room to doubt whether or not practice can ever be holistic, the rhetoric of the holistic foundation of occupational therapy is alive and well. It is necessary to turn to research on therapists' clinical reasoning in order to investigate the extent to which they actually embrace more holistic or reductionist modes in practice.

### **Mapping occupational therapists' reasoning**

Clinical reasoning has been of particular interest for occupational therapists over the last two decades. Rogers (1983) directed initial attention to this area and was followed up by the 1988 American Occupational Therapy Foundation Clinical Reasoning Study (Mattingly and Fleming 1994). Since then, articles on both sides of the Atlantic have proliferated (e.g. Medhurst and Ryan 1996, Munroe 1996, McKay and Ryan 1995).

Research into how and what therapists think suggests that they can be holistic and reductionist simultaneously. They are seen to employ a range of mental strategies -



logical, creative and intuitive - towards building an understanding of the individual patient/client (Finlay 1997a). Mattingly (1994) saw how occupational therapists thought simultaneously in two 'blurred frames' : phenomenological and biomedical.

As she explains :

The phenomenological aspects of occupational therapy practice are essential, and often require subtle and fluid reasoning by therapists, who must ascertain at what level they should ask the patient to consider the meaning of the disability as an illness experience. A purely bio-medical conception of clinical reasoning that treats the major task of the health professional as the identification of disease (or related dysfunctions) and the planning of disease-specific treatments leaves out too much of importance in the way occupational therapists must think in their work. (Mattingly 1994, p.92)

The literature in occupational therapy roughly parallels the work on clinical reasoning in medicine (Schmidt, Norman and Boshuizwn 1990, Elstein et al 1978), nursing (Benner 1984), physiotherapy (Higgs 1992) and general professional practice (Schön 1983, 1987). Most of the literature corresponds with one of Schön's two epistemologies of professional practice, namely : technical rationality and reflection-in-action. Recent research suggests we need to go beyond Schön's dichotomy and explore more subtle distinctions (Schell and Cervero 1993).

Four main types of reasoning have been put forward in the occupational therapy literature : scientific, narrative, pragmatic and three track reasoning.

**Scientific reasoning** - Explored initially by Rogers (1983, 1986), scientific reasoning is a systematic, logical cognitive process. Therapists are seen to reason using the scientific method of careful data collection, hypothesis testing and by applying research based theory and techniques. They formulate patients' problems



based on their knowledge of the patient's condition (e.g. diagnosis) and on the results of standardised assessments.

**Narrative reasoning** - In contrast, Mattingly (1991) and others emphasise a more phenomenological process whereby therapists' thinking is conceptualised in terms of them using stories to understand an individual's meanings. Their thinking is seen to involve empathy and improvisation as they picture patients/clients in terms of past, present and future time frames. It is through the creation of these stories that therapists are able to understand their patients'/clients' experiences of disability.

**Pragmatic reasoning** - Schell and Cervero (1993) offer a third formula, suggesting that clinical decision making is influenced by wider concerns. The socio-cultural context, therapy setting, practical/environmental constraints, plus the therapists' own life experiences will all play a part. For example, a therapist would plan a patient's discharge programme that takes into account the amount of home support available.

**Three track reasoning** - Fleming (1991, 1994a) synthesised these different strands, suggesting that therapists use different forms of reasoning in parallel and interchangeably. She uses the metaphor of a 'therapist with a three track mind'. The top track of reasoning is predominately *procedural*, following a hypothetico-deductive problem-solving way of imagining what needs to be done for a particular problem. A second *interactive* reasoning track allows the therapist to form an image of how a patient is responding. Here, the therapist is seen to act on subtle cues in order to motivate/engage the patient in treatment and to adapt treatment as it proceeds. Finally, *conditional* reasoning involves the use of logical and non-logical (intuition and imagination) methods to envisage the patient in current and future



social contexts. Fleming's phenomenological work suggests these three forms of reasoning relate to levels of clinical expertise, with procedural reasoning seen in all therapists, interactive reasoning in therapists with some experience, and conditional reasoning in expert therapists.

The specific literature on novice-expert differences also confirms the multi-layered nature of an occupational therapist's thinking while returning to the debate about the extent therapists can be holistic. It would seem that less experienced therapists have a tendency to hold on to more reductionist thinking and rely on clear bio-medical/technical models and practice routines. More experienced therapists have better developed schemata which allow for deeper, more complex links and understandings to be made. More experienced therapists also find it easier to be client-centred, and they relate to the client more as an individual (Benner 1984, Crepeau 1991, Robertson 1996).

Strong et al (1995) found experts considered a wider range of factors when making clinical decisions than did students. Both experts and novices employed narrative reasoning, but experts were found to utilise more scientific reasoning whilst novices used more pragmatic reasoning. Other researchers (Robertson 1996) have noted that experience changes the internal representations of clinical problems. For instance clinicians were seen to understand the client's perspective better than students. Clinicians also defined and organised information about clients more readily which allowed them to make predictions more confidently.

Research has also established that experienced therapists are able to form a clear procedural and interactional image before they meet a client, even if this image might



subsequently be revised. In contrast, novice therapists need to be with the client before they can form images and start reasoning (Ryan 1995). McKay and Ryan (1995) found that expert practitioners were able to formulate a more total picture of the client and were more rapid and accurate in their assessments. Novices needed to break the situation down into component parts, were more rule-bound and tended to focus on the immediate, rather than broader, situation.

Such studies parallel the wider health care literature on novice-expert reasoning. For example, Benner et al (1992) examined the development of expertise in critical care nursing and demonstrated that nurses at different levels notice different things and so 'live in different worlds'.

This literature on clinical reasoning offers rich insights into how therapists think. However, this research has limitations in terms of trying to understand the life world of the therapists. The focus on clinical reasoning privileges cognition and assumes that the way therapists think in some way determines their behaviour. A broader exploration of subjective experience, including emotions and/or unconscious responses, would give a more rounded picture. The work of Mattingly and Fleming (1994) on narrative and interactive reasoning stands out as one piece of phenomenological research which does manage to grapple with this broader subjective dimension.



## **2.4 THE EXPERIENCE OF 'DOING OCCUPATIONAL THERAPY'**

### **Satisfying and dissatisfying dimensions of practice**

Hasselkus and Dickie (1994) explored the experience of doing occupational therapy by investigating satisfying and dissatisfying dimensions of practice. They asked 148 occupational therapists in the United States to describe satisfying and dissatisfying experiences of practice. Three overarching phenomenological themes emerged from the narrative data : change, community and craft. In all these dimensions, the relationship with the patient/client and the competency of the therapist were seen as key features of the therapist feeling satisfied and effective at work.

The dimension of change was linked to the idea of 'making a difference' and figured prominently in the therapists' stories. They all aimed to bring about change in their patients which would enable them to regain capabilities and return to their previous social contexts. The therapists felt particularly satisfied when they were challenged by difficult cases but were able to contribute to recovery and positive outcomes. The greater the level of struggle, challenge and involvement with the patients/clients, the greater the satisfaction. The obverse also applied : dissatisfaction was linked to not being able to make a difference (for example, where the patient was unable to change or where gains were undone on discharge). Parallels were made here with Fleming's (1994a) conditional reasoning.

The dimension of community was related to Fleming's (1994a) interactive reasoning with themes of relationships and the need to be valued by others. Hasselkus and



Dickie extended their understanding to encompass the idea that therapist-patient relationships involved collaboration where together they worked to bring about change. In particular, the relationship was conceptualised as creating a mutually agreeable story, and the success of the therapy was measured by rewriting a positive life story for the patient's future. Therapists described with enthusiasm how the evolving relationship was a source of real satisfaction.

The dimension of craft (linked to Fleming's 1994a notion of procedural reasoning) was seen to encompass the processes of competently managed, holistic, inventive therapy. Therapists experienced a greater sense of satisfaction when they were confronted by particularly difficult problems which they negotiated successfully, using their creativity and therapy craft. Therapists also expressed satisfaction when learning new skills or enjoying some particular modality of their work (such as splint making).

In an earlier study, also using a phenomenological approach, Hasselkus and Dickie (1990) identified five themes of meaning in occupational therapy practice :

- a) making a difference, where therapists felt satisfied when they could make a difference identifying a diagnosis or enabling change.
- b) being valued by others, where therapists experienced satisfaction on receiving positive feedback from clients and other team members
- c) sense of initiative, where satisfaction derived from being the prime instigator in a treatment
- d) sense of inventiveness, where satisfaction stemmed from being creative and overcoming challenges



- e) agreeableness, which encompassed a mutually satisfying relationship with a motivated client and smooth, prolonged treatment with positive outcomes.

Whilst authors such as Hasselkus and Dickie (1994) and Mattingly and Fleming (1994) have made a substantial contribution to the phenomenological literature on the experience of being an occupational therapist, their research is confined entirely to the experience of North American therapists. Similar qualitative research has not yet been carried out in the United Kingdom. However, quantitative research suggests some parallels. In a survey of 211 occupational therapists based in the United Kingdom carried out by Allan and Ledwith (1998), 78% of the subjects said they would choose occupational therapy if they were starting their career now; for many, of those surveyed, occupational therapy was indeed a satisfying and varied job. The limitation of such quantitative surveys is the emphasis on sample size which works against a deeper exploration of different meanings such as what is experienced as 'satisfying' or 'stressful'. Furthermore, information on the differences between individuals' perceptions is lacking.

Other occupational therapy research has attempted to identify meanings. For instance, helping others was found to be a key value held by occupational therapy students (DePoy and Merrill 1988). A sense of achievement and having positive interpersonal relationships with others have been long identified as important sources of job satisfaction (e.g. Bordieri 1988). Fleming and Piedmont (1989), studying therapists' perceptions, noted how important it was to therapists to be valued by others. Bienes (1989) identified making a difference as possessing a central meaning in occupational therapy : "People must make a difference for themselves or others in



order to function and continue to grow... This, in fact, is a measure of health, for the person and for society" (cited in Hasselkus and Dickie 1990, p.202).

Similar themes about satisfactions and meanings in work emerge in the wider health care literature. White (1996), using repertory grid technique, identified six key themes for nurses : connectedness, job satisfaction, effectiveness, ability threat to self and pressure of work. Robertson and Cummings (1991) found that the factors which imparted the most job satisfaction were challenge, recognition from patients and positive interactions with other nurses. Strumph (1985) suggested that job satisfaction occurred when there was autonomy, recognition and challenge to develop new skills. Morse et al (1992) argued that care givers need to fully engage with clients and to act reflexively in response to their needs. The relationship with patients/clients is thus seen to be a critical dimension of any satisfying health care work.

### **Relationships with patients/clients : caring or power?**

The therapist-patient relationship is fundamental to, and at the core of, occupational therapy practice. Peloquin (1993), Schwartzberg (1993) and Crepeau (1991) all stress the importance of the relationship in terms of how it contributes to both positive and negative treatment outcomes. The relationship is seen as essential for engaging patients in treatment. Finlay (1997a) argues the most potent element of treatment is the therapist's 'conscious use of self' as a 'treatment tool'.



Schön (1983) explored how professional-client relationships are sources of meaning, learning and renewal for professionals as well as clients. Ramos (1992), in her investigation of nurse-patient themes within relationships, found a striking degree of unanimity among nurses that their relationships with patients were central to their professional health and satisfaction. She noted that deep relationships (characterised by intense bonds, mutuality and reciprocity) were perceived by nurses as the most beneficial for patients and thus satisfying. Nurses who did not engage in such intimate attachments and were mainly involved in routine, technical tasks, felt less motivated in their work. A similar conclusion was reached by Benner (1984), while Kleinman (1988) and Devereaux (1984) found that good therapeutic relationships motivate and assist clinicians to maintain an interest in patients and a sense of engagement in work. The process of helping others is “satisfying, therapeutic and curative” (Devereaux 1984, p.795).

In specific reference to occupational therapy, the American Occupational Therapy Association (1993) outlined seven core values underpinning the relationship between therapists and patients : altruism, equality, freedom, justice, dignity, truth and prudence. To what extent are these values actually reflected in practice? For one thing, as Crabtree and Lyons (1997) argue, the equality value presents a singular challenge given the power imbalance inherent in therapeutic relationships. However, balancing this is the occupational therapists’ client-centred philosophy which emphasises the collaborative, caring nature of the therapeutic relationship. These tensions between power and care have been much debated (e.g. Day 1981) and a rich pool of literature attests to the complex, multi-levelled nature of professional-client relationships.



### A Caring Dimension

Caring has been identified as a fundamental element of the therapeutic relationship (Devereaux 1984, Rosa and Hasselkus 1997). For occupational therapists, to be caring means to "know and understand the emotions of illness...and to acknowledge this in empathic, yet therapeutic, responses..." (Devereaux 1984, p.792). In the nursing literature, caring is equated with being loving, understanding, compassionate and warm, in contrast to being efficient, competent and functional. Smith's (1992) work on the emotional labour of nursing picked up these themes, arguing for the importance of emotional care and noting that patients were found to judge the quality of nursing according to its emotional style. However, commonalities between nursing care and occupational therapy cannot be assumed and the literature suggests there may be some differences, though this has not been specifically studied.

Researching the occupational therapy experience, Rosa and Hasselkus (1997) explored how therapists seek to 'connect with' patients through both helping and working together. Therapists were found to rejoice in their patients' successes and despair in their failures. This process of helping was seen as a collaboration between therapist and patient : therapists would not perceive themselves as able to help if they could not work together with a patient.

Caring has also been associated with personal feelings. In this context, the personal nature of professional caring has been explored by a number of researchers. Rosa and Hasselkus (1997) argued that therapists' personal and professional identity is tied up in their relationships. For instance, some therapists described their relationships with patients in terms of being a 'friend' or 'parent'. Such personal involvement has



been shown to make work rewarding and contribute to personal growth (Peloquin 1993), although it can also be a source of stress and burn-out (Florian, Sheffer and Sachs 1985).

Peloquin (1990), in reference to American practice, described how three images of occupational therapists dominated patients' stories : those of technician, parent or collaborator/friend. Technical therapists were seen to equate expertise with care, while parental therapists sought to make decisions in the patient's best interests. When occupational therapists acted as technicians or parents they seemed to value competence rather than the more caring aspects of relationships favoured by the collaborative therapist. Peloquin suggested therapists who act as technicians and authoritarian parents reflect society's preference for rational problem fixing but that this can compromise more personal caring. She also discussed how the routinization and rationalisation of health care institutions may, while promoting efficiency, curtail the element of care.

Burke and Cassidy (1991) echoed these arguments, pointing to the changing nature of the therapist-patient relationships in the context of practice in the United States. They suggested that growing numbers of occupational therapists are being obliged to use technical protocol-driven approaches to treatment, in the process moving away from care which emphasises an individualised treatment approach.

Occupational therapy (in common with other female-dominated health professions) is often described as one of 'the caring professions' (Freedberg 1993). However, what this caring actually means within the therapeutic relationship is contested. Further, therapists must struggle to find a balance between being caring and being detached;



while being involved, they must strive to maintain sufficient distance to manage their work competently.

The 'art' of caring has been contrasted with the scientific/technical aspects of health care. For instance, the therapists in Peloquin's (1993) study contrasted caring with competence, valuing each of these in different ways. Whilst many health professionals strive to 'care', others aim to establish a professional distance within day-to-day interactions (Stewart 1990, Peloquin 1990). Adopting a compromise position, Curzer (1993) argued the case for 'benevolence' as a role virtue for health professionals rather than 'caring'; he argued that professionals should project caring whilst limiting their emotional involvement. Devereaux (1984) noted it is impossible to care with great intensity for every patient and some distance is necessary for self-preservation.

Davies (1998a) picks up Purtilo's (1993) notion of 'meaningful distance'. This acknowledges professionals' emotional responses but urges professionals to avoid over-identification as well as under-identification. She advocates developing new terms to value and harness the commitment professionals show instead of the classical image of the detached professional or the more recent image of the professional motivated by monetary gain. Studies on medical socialisation highlight how medical students start with high ideals about helping people and how these ideals are moulded into 'detached concern' (Fox 1974, Bennett 1987). Students are taught to distance themselves emotionally from their patients' suffering. In the extreme this socialisation process can transform idealism into cynicism (Becker et al 1961).



In contrast, Schön (1983) explores professional-client relationships in term of a contract of shared norms and expectations where the client (to a greater or lesser degree) complies with the professional's expert opinion. In return the professional has a responsibility to be competent and accountable and to try to understand the client's needs/meanings. He recommends a move away from the concept of 'professional expert' to that of 'reflective practitioner', with the latter no longer needing a professional facade. The reflective practitioner, argues Schön, seeks connections with clients' thoughts and feelings, and allows knowledge to emerge out of the relationship.

Morse's (1991) large-scale Canadian study proposed there were four types of nurse-patient relationships : clinical (brief contact); therapeutic (interaction professional); connected (intensive); and over-involved (intimate). The relevance of such a typology is to note how with increased throughput of patients in hospitals, many relationships remain at the clinical level. But as Jones (1994) recognises, nursing theories are encouraging nurses to move towards more 'connected' relationships where the patient is seen primarily as a person first.

Lyons' (1997) study of student-patient relationships in Australia suggested occupational therapy students experienced difficulties in reconciling their inclination towards intimacy with conflicting expectations for emotional and social distance. On the one hand, students attempted to be supportive, to develop rapport and even give friendship. On the other, 'friendship' was seen as an inappropriate professional role. Students therefore struggled to put aside personal feelings in case these contaminated their professional judgement and responses. This study stands out as



one of the few which attempts to describe the occupational therapists' ambivalent experience of their world of relationships.

### A power dimension

A number of studies highlight tensions between 'care' and 'control', recognising that a power dimension is embedded in therapeutic relationships (Lyons 1997, and Wilding 1982). Hugman, noting that "social power is an integral aspect of the daily working lives of professionals" (1991, p.1), argued that power in the remedial professions is not only seen within formal hierarchies but also in the way those hierarchies intersect with professional boundaries, relationships with service users and structures of gender domination and racism. In this way caring is seen both to emerge from, and to be sustained within, power relationships.

Control over the therapy process typically resides with the professional who has the expertise and authority to define the problems of patients/clients. They then control the solutions to these problems by their capacity to prescribe and control access to treatment (Goldin 1990, Maynard 1991). Within treatment, professionals maintain control, for instance by demonstrating a lack of respect for service users' opinions (Kalyanpur and Rao 1991). Alternatively, the therapy process can become a 'battle' when the patient/client acts aggressively, complains and refuses to comply or take responsibility for treatment (Rosa and Hasselkus 1997). As Crepeau (1991) pointed out, the structure of the relationship favours professional opinion and control, thereby preventing therapists from understanding how patients experience their conditions.

In Lyons' (1997) study of occupational therapy students, he found they needed to assume authority and maintain control in their interactions with patients/clients. He



suggested that the game plan for an inexperienced, unconfident student is to maintain control (particularly over patients' or clients' unruly, undesirable behaviour) in order to survive. Other studies highlight the distinction between being in control and feeling in control. For instance, Jarman et al (1997), using an interpretative phenomenological approach, explained how therapists working with eating disordered clients may well have the professional power to direct treatment; however, the extent they *feel* in control of the process varies between team members.

The power dimension within relationships is also exposed in the pattern of interactions observed between professionals and clients, and this can be set within a wider social context. Ahmed (1986), in a study of interactions with social workers, showed how racist assumptions operated which both defined and controlled Asian women clients (cited in Miell and Croghan 1996). Research in the field of nursing has revealed how nurse-patient interactions can often be superficial, routinized and related to tasks, with nurses exerting control over interactions (Rosenthal et al 1982).

Routines in care which insulate staff from real contact with patients/clients are seen to be both defensive and part of a process of bureaucratisation which occur in any large organisation. Seen in this light, routines have several functions : to socialise patients into compliant roles; to enable health professionals to control the flow of work; and to exert control over the staff themselves (Jones 1994).

Morrison's (1994) phenomenological investigation into patients' experience of 'crushing vulnerability' exposed how very vulnerable patients feel in contrast to nurses' position of control and power. Behaviour such as always deferring to the nurses as "nurse" was shown to reinforce unequal status. Similarly, Hewinson (1995)



demonstrated how nurses initiate the bulk of communication and that control of communication is the major way in which they can exert power over patients. For example, the routinized language professionals use to label patients, like 'dearie' or 'good girl', can reinforce the reality of the patient being a child and the nurse a parent. Arguably, it is through the use of endearments that nurses attempt to reconcile a caring approach with a controlling function.

Power, then, is exercised through the use of language - in the labels and social evaluations that health professionals apply. Numerous studies over the last thirty years have highlighted how health professionals tend to label and categorise their patients in terms of moral evaluations (e.g. Stockwell 1984, Jeffrey 1979, Murcott 1981, Lorber 1975). In particular, people are seen as 'good'/'bad' or 'popular'/'unpopular' patients. Good patients are co-operative, appreciative of their treatment, cheerful and uncomplaining despite being seriously ill. They allow staff to practise their skills or specialities and usually get better. Bad patients are demanding, uncooperative and ungrateful. They make staff feel ineffective and tend to be condemned by staff.

In simplistic terms, such evaluations often relate to the professionals' workload - good patients make work easy, bad patients obstruct and create difficulties (Duff and Hollingshead 1968). In their research on nursing care, Smith (1992) and others noted young nurses preferred patients in their own age range as they made fewer physical demands and were more responsive socially. In addition, slotting patients into convenient categories such as 'difficult' allows nurses to distance themselves emotionally and so better cope with their workload. Kelly and May (1982) attributed



nurses' definitions of patients to the way they legitimise (or not) the nurse's role (i.e. an appreciative patient confirms the role).

Other research throws doubt on the idea that the use of evaluative labels is in any way simple or predictable. Instead, professionals are seen to employ multiple, often contradictory evaluations. Johnson and Webb (1995) argued that social evaluations are not tied to patients' traits (for instance, those relating to social class); rather, evaluations vary between individuals and in different contexts. Dingwall and Murray (1983) suggest categories are fluid and that initial evaluations can change - for example, the patient who starts off as 'deviant' can be reclassified as 'clinically interesting'.

Health care research reveals an ubiquitous use of moral evaluations, with professionals being forced to judge the social worth of people in order to balance competing claims on time and resources. Crucially, these evaluations carry with them critical consequences where people are treated differentially according to their illness, class, behaviour, appearance and so on. A classic illustration of this comes in Jeffrey's often quoted 1979 study. This demonstrated how doctors in accident and emergency departments routinely classified some patients as 'normal rubbish' (e.g. the 'normal drunk' or the 'normal overdose') and how that label carried with it significant consequences such as delaying resuscitation. In a more recent study, Herbert and Weingarten (1991) offered a personal account of how negative feelings towards an anorexic patient may well have influenced the decision to allow her to die (cited in Jarman et al 1997).



For most health care practice, the consequences of social evaluations are not usually of a life and death nature, but the evaluations applied can be stigmatising, stereotyping and disempowering. For instance, Roth (1972) noted that rehabilitation patients typified as uncooperative/abusive were promptly discharged. More recently, Johnson and Webb (1995) showed how nurses interact with patients in qualitatively different ways according to their view of them as people.

This review of the wider health care literature on power and labelling has raised a number of questions. Firstly, to what extent do these studies reflect the occupational therapists' experience? Finlay (1997b), drawing on material presented in this thesis, offers one of the first reasonably comprehensive accounts of the views of patients or clients from the perspective of occupational therapists. This study is also notable as it refers to therapists practising in the United Kingdom.

Secondly, to what extent does power only operate in one direction? Little research seems to have been carried out on patients' and clients' power over therapists in the health care context. More specifically, although violence in the work place is described, this violence tends not to be conceptualised in terms of patients and clients being abusers. That said, the literature is now beginning to acknowledge more of the complexities of the situation. Jarman et al (1997), for instance, explore the different types of control anorexic patients can wield. Thompson, Clare and Brown (1997), in a study of those working in the learning disabilities field, explore how female care staff are exposed to male sexual behaviour and how this can be experienced as both threatening and abusive. The lack of clear management guidelines within gendered hierarchies is seen to further exacerbate the problem.



Thirdly, the literature raises questions about the nature of professional power and whether it is always a negative force. It is interesting to note the different ways power is understood in the literature. Hugman (1991), writing as a sociologist, emphasises the positive aspect of how certain patients/clients manage to challenge the legitimacy of professional expertise and control. Rosa and Hasselkus (1997) take the therapist's side and express the pain such battles cause and how therapists internalise messages of failure.

#### Collaboration - the new professionalism?

A number of researchers have argued for professional-patient relationships to be based on a more equitable distribution of power - one based on mutual collaboration, participation and partnership (Yerxa 1980, French 1994, Ashworth 1997). As Crepeau (1991) and others note, empowering relationships depend on the willingness of professionals to drop their expert position and become an ally. In practice this means creating learning opportunities and enabling patients/clients to participate actively in treatment (French 1994, Kalyanpur and Rao 1991, Peloquin 1990). In the field of rehabilitation, for instance, researchers have focused on the need to allow patients to take more responsibility for, and initiative in, their treatment (Whalley Hammell 1994, Banja 1990). Steele et al (1987) described the 'activated' patient who rejects the passivity of the sick role and seeks involvement and explanation. As a result the patient is more motivated and satisfied with the treatment.

In tune with this approach, occupational therapists' client-centred values emphasise the need for a collaborative rather than prescriptive relationship with patients/clients. Yerxa (1980) referred to a mutual cooperation model where power, ownership and



responsibility for treatment are shared. Further evidence from interactional analysis suggests that effective communication and successful therapy depend on an appreciation of the clients' world : much is to be gained by enlisting the client as an ally (Jenkins et al 1994 and Cassell et al 1977).

Such studies, which exhort therapists to be collaborative and client-centred, have a tendency to proffer easy prescriptions of the 'ideal relationship'. In reality, different situations demand different levels of collaboration. Further, each relationship needs to be negotiated on its own individual terms. Crabtree and Lyons (1997) go some way to recognise this process of negotiation. They noted that while the relationship can never be completely 'equal', a balance can be struck whereby the professional relinquishes some power to gain patients' cooperation. These researchers observed how a therapist, armed with her own idiosyncratic humour, turned away from offering a directive challenge and, instead, engaged in interactive reasoning which avoided alienating her patient.

Much current research arising from a social constructionist perspective calls for health professionals to become more aware and reflexive about the problems of differential power between clients and professionals. As Opie explains, "Working reflexively includes acknowledging the inevitability of differential power relations between clients and health professionals and the development, and on-going critique, of modes of interaction which seek explicitly to minimise that difference." (1995, p.273). Her research examined the ways professionals teams discussed their clients and formulated care plans. She found that the teams' discourses were dominated by medical/physiological concerns despite the fact that they defined themselves as being holistic and client-centred. Of greater concern was how issues of power and control



surface in competing representations. Whilst team members sought to consult with and empower clients, their practice was disempowering. For example, one team discussed how they needed to "get heavy" with a client who was represented as being deviant, uncooperative and ungracious. As Opie points out, this "produces the binary of 'proper' patients as grateful, docile and, above all, rational, able to make choices which complement the team's understanding of its role and its work" (1995, p.272). The task for the team in this instance is to become aware of such processes with a view to actively deciding whether or not to maintain them.

In similar vein, Davies (1996, 1998a) calls for a new professionalism - one that dislodges the gendered model of professionalism and places at its centre 'reflective solidarity'. The new professional values need to reflect practice which empowers clients and engages in mutually supportive, collective team relationships. Others have joined in this call for a new professionalism : Hugman (1991), for instance, calls for greater partnership and participation in a 'democratic professionalism' that empowers both users and professionals. However, the process of empowering service users is not straightforward and will depend on the demands or needs of the particular situation. The task of empowering professionals themselves is also dependent on their work context and here further challenges remain.

### **Therapists under siege : the pressures of the work context**

Professionals are under siege. Everywhere in the developed world they are being challenged. They feel threatened and defensive, overloaded and highly pressurised. This is as true in health care as in other professions. They feel let down by the public they serve, their professional bodies to whom they hold allegiance, and by the politicians who provide the fiscal and policy frameworks within which they practise. (Fish and Coles, 1998 p.3)



Among the major pressures identified by Fish and Coles are the following :

- a more demanding, sophisticated public who challenge professional autonomy
- a blurring of traditional role distinctions and demand for multi-professional working which challenges professional identity
- marketisation and contract culture which replaces professional control with competition
- new social policies which challenge notions of professional accountability.

A number of pressures arising out of the broader work context are therefore seen to undermine the professional practice of the therapist. These pressures can be understood to occur at three different levels : those of the workload, the team, and the wider society with its organisational pressures and political constraints.

### Workload pressures

Although studies (such as Bordieri 1988) indicate occupational therapists experience moderately high degrees of job satisfaction, a number of researchers have found evidence of stress related to burn out and excessive workload. Greensmith and Blumfield (1989) found that an unrealistic workload plus lack of professional status were key reasons occupational therapists gave for leaving the profession. Sweeney et al (1993b) identified four main sources of job stress for occupational therapy staff : lack of professional identity, lack of recognition, pressure of demands and unrewarding patient contacts. Brollier (1985b) found therapists in the United States satisfied with their choice of work but not with the amount of work or with their



financial rewards. Rees and Smith (1991) identified issues relating to professional status, overload and the nature of the work as contributing to therapists' stress levels.

These studies are useful in pinpointing problematic pressures. However, the use of survey methodology limits the degree to which the actual experience of stress is explored. More qualitative research is needed to unravel what lack of professional identity and recognition actually means in practice, and how this varies for individual therapists working in different areas.

Looking more broadly at the health care literature, Aguis et al (1996) pinpointed the perceived stresses for consultant doctors as demands on time and clinical responsibility. With reference to nursing, Burnard (1991) identified time pressures, instant decision making and lack of control over circumstances, amongst other factors, as producing stress.

Inadequate supervision is seen as a key factor behind burn out. Allan and Ledwith (1998) investigated self-reported levels of stress in 211 senior occupational therapists practising in the United Kingdom. They linked levels of stress with perceived needs for supervision and future job intentions. Roughly one third of the staff reported high or very high levels of stress and 19% reported they intended to leave occupational therapy within five years. Only 25% reported feeling satisfied with the level of supervision they received. Evidence suggested that those wanting to leave the profession lacked opportunities to off-load feelings.

For some health professionals, patient contact itself can be a source of stress.

Research indicates the low priority health professionals give to tending to themselves



sufficiently (Cox 1988) and how they so easily become 'casualties of caring' (Bailey 1985). Where professionals work in demanding clinical areas, where they are forced to handle much emotional suffering and risk potential violence, there is even greater need to attend to their own coping (Burnard 1991, Sullivan 1993).

Patient contact has also been experienced as stressful in other ways. For instance, Leonard and Corr (1998) found that basic grade therapists experienced 'making mistakes' in clinical decision-making as stressful. It is not surprising in this context that Sweeney et al (1993b) showed that junior occupational therapists found patient contact more stressful than did their senior colleagues - particularly as they carried bigger case loads.

Other studies reiterate the point that stress is particularly prevalent amongst newly recruited occupational therapists (Hummel and Koelmeyer 1992 and Hummel et al 1995 cited in Adamson et al 1998). Parker (1991) identified a range of stress factors for newly qualified therapists, including huge responsibilities and lack of supervision. Researching physiotherapy graduates, Scutter and Goold (1995) found a high proportion of practitioners experienced moderate to high levels of emotional exhaustion and depersonalisation.

A different picture, however, emerges from the research of Allan and Ledwith (1998). It was the more experienced staff, they found, who were more dissatisfied (regardless of clinical area). Similarly, Brolhier et al (1987) found that occupational therapists in the United States, who spent less time with patients, suffered greater emotional exhaustion and feelings of depersonalisation. Comparing therapists



working in physical versus psychosocial settings, they identified similar moderate levels of burn out in both settings.

Interestingly, research indicates workload stress may be less of an issue for occupational therapists than for some other professionals. Rees and Smith (1991) found that occupational therapy staff had a level of stress similar to that of junior doctors - less than that found in physiotherapy and most nursing groups. Rogers and Dodson (1988) argued that occupational therapists experience less burn out because the creative element in their work and opportunities for social interaction with patients as active collaborators in treatment may shield them from emotional depletion.

Such findings are underscored by the more general point that health care professionals feel content at work when they are able to perform well, be competent and be in control. It is when they feel unsure, under pressure, or unable to practice what they perceive is their role, that work becomes more dissatisfying (White 1996).

Picking up the theme of control, no discussion on work pressure is complete without a mention of Menzies Lyth's (1988) psychodynamic work, where she set an individual's stress and coping within a wider institutional context. Although she studied nursing and hospital practices in the late 1950s, the findings still appear relevant today and they also seem to apply to all health care professionals. One of her key findings was the high levels of stress and anxiety generated by nurses' caring tasks and the nature of institutional working. Her central thesis was that individual work practices and the organisation as a whole evolve institutionalised defences against anxiety, defences which in turn reduce job satisfaction. These defences



include : the detachment/denial of feeling; depersonalisation of the patient; and attempts to eliminate decisions by standardising tasks and sticking to established procedures.

Other studies have further explored the nature of professional defences. Morrison (1994), picked up Kleinmann's notion of doctors as 'disabled healers' and discussed how professional masks may protect practitioners from being overwhelmed by patients' demands. His caveat is that masks can also cut the practitioner off from caring, humane responses.

Underlying qualitative studies such as Menzies Lyth (1988) and Morrison (1994) is a recognition that dealing with patients' or clients' distress and pain is itself a painful process. However, the literature is often silent when it comes to exploring the raw emotions experienced by health care professionals. It appears that some emotions are more acceptable than others. Whilst the literature regularly grapples with 'positive' aspects such as caring, 'negative' emotions (such as therapists' anger, fear and loathing) are rarely explored.

### Teamwork pressures

A number of studies demonstrate the role of the wider multi-disciplinary team as both a positive and a negative force, emphasising how good relationships are associated with relief of stress whilst poor relationships cause stress (e.g. Hopkinson et al 1998).

On the positive side, Sweeney et al (1993a) suggested that work stress was considerably lessened through team support and interaction. Other researchers (such as Cherniss 1980, Leonard and Corr 1998) have demonstrated the importance of



supervision and support from other team members. Davis and Bordieri (1988) found that occupational therapists in the United States reported feeling satisfied with their work and their interpersonal relationships with co-workers.

On the negative side, McNeely (1994) revealed that nurses found communication with other nurses, doctors and departments to be a major source of stress.

Hopkinson et al (1998) reported that community psychiatric nurses experienced considerable role uncertainty, where misunderstandings about boundaries and responsibilities coming from management and other health professionals were considerable sources of stress. Toulouse and Williams (1984) pointed to poor liaison with other professions as a key area of dissatisfaction for newly qualified occupational therapists, while Øvretveit (1997) found the erosion of clear professional roles a particular source of tension in a community mental health team whose members felt that others were encroaching on valued areas of work.

Other research identifies how professionals feel both positive and negative about teamwork. For instance, the nurses in Morrison's (1994) study saw the ward environment as being supportive but also hierarchical, with political decisions taking precedence over clinical ones. These nurses sought to work more autonomously in the community.

The literature reveals two particular barriers to positive, collaborative teamwork - hierarchy and competition. In the case of hierarchy, practitioners in a team are likely to have different status, power, pay, experience and conditions of work - and all of these are a potential source of tension and disempowerment for team members (Finlay, forthcoming). For instance, ideologies of gender can explain the relations



between the 'professional work' of men and the 'supportive activities' of women (Davies 1996). Here, nursing can be viewed as an essentially feminine occupation with (female) nurses traditionally deferring to, and acting as, 'handmaidens' to the male doctors. As Dalley (1989) recognised nurses tend to be locked in deferential relationship with doctors - relationships which they resent but from which they cannot escape.

One particular study of status inequalities was that of Adamson et al (1995) who compared Australian and British nurses' perceptions of medical dominance. Their results indicated that both sets of nurses were dissatisfied not only with their pay and working conditions, but also with their status. The power differential built into the nurse-doctor relationship acted as a barrier to collegial relationships. Other studies have also revealed that many health professionals do not feel regarded as equals and that they struggle to be valued by their colleagues. For instance, in a study by Kenny and Adamson (1992), 73% of the professionals interviewed expressed concern that doctors did not understand their role or regard them as equals.

Competition between team members arises in two ways. Firstly, in the context of the marketisation of the health service, practitioners compete with each other for funds, patients/clients and even their jobs (Jones 1998). Secondly, competition can result from a clash of professional ideology where members battle to assert their own views, for instance about how clients should be treated. As Sheldon puts it :

The different theoretical assumptions about mental ill health held by psychiatrists, nurses, social workers and the staff of voluntary bodies stand as serious and definite obstacles to co-operation. Mention the "medical model" on a social work course and you will hear the kind of background hissing once reserved for the characters with moustaches and black hats in silent movies. (1994, p.89)



Whatever the underlying conditions, competition leads to splits in the team. This usually involves : a) destructive sub-grouping as sub-groups attempt to usurp power and exclude others (Parkin 1979); and b) negative stereotyping of the 'other' . In the latter case, other professional groups are commonly put down, doctors are labelled as 'pill pushers'; 'social workers as 'bleeding hearts' and occupational therapists as 'basket weavers' (Finlay, forthcoming). Such developments, which impact negatively on the individual practitioners concerned, occur in a wider context which needs to be taken into account.

#### Organisational pressures and political constraints

Much of the literature suggests that health care professionals are most pressured by the organisation at large, whether in the form of demands from management, or whether deriving from the wider socio-political health care context. Allan and Ledwith (1998) noted that amongst therapists who said they would not choose occupational therapy as a profession if starting again, the most commonly cited reason was changes/problems in NHS policies. As White comments, "the hospital setting appears to require a bureaucratic nurse who is able to function in an unquestioning manner and to accept the stress of the workplace as a normal and therefore acceptable scenario" (1996, p.149).

One example of organisational pressure often commented on is the demand to document all actions and procedures. For instance, the greatest overall stressor for basic grade occupational therapists was found to be too much paperwork (Leonard and Corr 1998). Here, therapists struggled with their report writing, hampered by



their limited experience and shortage of time, and harassed by having to operate in a potentially litigious climate which demanded precise standards.

At a different level, the context of marketisation and the contract culture has resulted in practitioners being pressured to be more efficient and to cut costs. Opie (1995) develops this theme in terms of the implementation of managerialist principles, suggesting that while the latter are intended to be productively efficient, they in fact can have the reverse effect. The implementation of such principles, Opie argues,

has meant in practice a predominant concern with outputs, continued restructuring, the loss of clinical expertise, professional uncertainty, high staff mobility, shrinking resources, and a reduction of training opportunities for many staff. In the day-to-day experiences of many health professionals in New Zealand there is a distinct absence of organisational conditions which would enable the development of reflexive team work. (1995, p.276)

Similarly, the pressures inherent in a market context force professionals to seek to justify their existence - an on-going pressure for most practitioners. This is expressed in Bousfield's (1997) study of clinical nurse specialists in the following terms :

The pressures to define the role and evaluate its effectiveness are constant and forceful, therefore leading the individuals to feel a dissonance yet at the same time tremendous internal pressure to fulfil self-imposed demands and the expectations of the organization. (Bousfield, 1997 p. 249)

Lloyd-Smith (1997) found changes in management (specifically, moving to Trust status) created tensions and anxieties for the staff, although these were often not discussed openly. Therapists were found to be more open, however, about their concerns regarding the market-style culture and its impact on both the ideals of the NHS and the philosophical base of occupational therapy. Many therapists expressed feeling disturbed by "the insidious creep of commercialisation... When the cut and thrust world of market met real live patients, uneasiness was quickly replaced by



hostility" (1997, p. 312). Significantly, there are few references in the occupational therapy literature to the wider socio-political and economic context. Papers like Lloyd-Smith (1997) start to redress this balance.



## **2.5 RESEARCH AIMS**

This section identifies the research aims I have derived from different empirical and methodological considerations arising out of the preceding literature review. Whilst the gaps exposed in the literature review can be said to provide the rationale from my research, strictly speaking, the nature of phenomenological enquiry has meant that justification of these aims came only towards the end of my research when I completed the literature review.

### **Empirical considerations**

A picture of the occupational therapy world emerges from this literature review of a profession which is insecure about its role and identity - an insecurity which is aggravated by the reality of an ambiguous role and diverse practice. The sheer volume of occupational therapy literature devoted to examining the profession's role and the attempt to negotiate a theoretical base attests to this. At the same time, however, much research demonstrates how occupational therapists gain meaning and satisfaction from their practice, their client-centred relationship with patients/clients and their complex clinical reasoning. But this practice is stressful as therapists are challenged by pressured workloads, disempowering team relationships and the demands of the wider health care context.



It is assumed that these emerging themes somehow reflect occupational therapists' preoccupations in the 'real world'. In other words, scientific approaches to lived experience must in some way reflect the life world (Merleau-Ponty 1962). For this reason, my literature review, analysis and discussion 'tap into' similar concerns.

Despite these similarities, nowhere in the literature is there an exploration of the life world in terms of explicit references to embodiedness, temporality and spatiality - concepts which my own research sets out to explore. My work also challenges the simplistic, and in some cases, sanitised accounts of occupational therapy experience presented in the literature.

Because of these limitations, I have had to draw on a wider pool of literature. Here, many of the findings relating to other health professions seem to mirror the experiences of occupational therapists. Examples of this include the experience of professional-client relationships as a source of meaning, learning and renewal and the enactment of caring within a broader power context. These commonalities between different health professionals suggest that occupational therapists may well share a life world with other health professionals. For this reason, I include references to the wider professional literature in both my review and the discussion.

However, there is also a difference between professional concerns which warns against making easy generalisations. For example, in contrast to that on nursing, occupational therapy research makes more of role issues and is less concerned with the issue of caring. I therefore do not assume the existence of commonalities with other health professionals but I note where similarities emerge. One instance of this



is how community psychiatric nurses seem to struggle with role issues to a similar degree as occupational therapists.

Comparisons between professional literatures are problematic in part because the occupational therapy research base, in contrast to that of other professions, is relatively new and is only beginning to be developed. Investigations which have taken place in the wider health care arena (for instance on power, labelling or professional-client interaction) have yet to be taken up in reference to occupational therapy. Where I draw on the wider literature, I therefore make the assumption that parallels are likely to be found.

## **Methodological considerations**

The literature review reflects a striking paucity of directly relevant, quality phenomenological material. The phenomenological research encountered on the life world of the health professional would appear to be both patchy in content and occasionally confused in terms of method. In terms of content, much of the phenomenological literature seems concentrated on the experience of health and illness, rather than on the experience of professionals. Even where the latter is attempted, the research often takes a relatively narrow approach, for instance looking at the nurse-patient relationship or practice in a specialist field. This type of research, then, is only partially relevant to my own which aims to look at wider experiences.



The phenomenological literature available which does focus on the occupational therapy experience is rich but limited to a handful of studies. These studies (namely Hasselkus and Dickie 1994, Mattingly and Fleming 1994 and Crabtree and Lyons 1997) offer important insights but tend to be confined to specific topics (e.g. clinical reasoning); they are not broader investigations of the 'the life world'. And as they refer solely to research in North America and Australia, their findings may not be relevant to the British context.

In terms of methods employed, some of the so-called phenomenological literature available is not entirely convincing. Misunderstandings about the nature of phenomenological enquiry and underlying philosophical ideas are apparent.

Confusion about the status of subjectivity and the meaning of concepts such as phenomenological reduction and intentionality is apparent in much of the health care literature. The sharp critique of nursing phenomenology (which, in particular, highlights misunderstandings nurses have about the ideas of Husserl and Heidegger), by Crotty (1996), Paley (1997) and Koch (1995), reinforces this point. I have therefore sought to be cautious and critical when attempting to apply insights from other studies.

The problem in using phenomenological methodology is how to apply the dense philosophical ideas. The original phenomenologists were philosophers who offered little in the way of practical guidelines - a separation Crotty (1996) presents and pursues as philosophical versus scientific phenomenology. The gap between theory and practice is thus fraught with uncertainty and contradiction.



Despite these difficulties, it should be noted that phenomenological methods have been developed which can usefully be employed to investigate professionals' experiences. Examples include Giorgi's (1975) elaboration of Husserlian ideas and Smith's (1996) pragmatic attempt to bring together ideas from discourse analysis and phenomenology in an 'interpretive phenomenological approach'.

However flawed, the available phenomenological literature remains interesting as it brings everyday experience alive. Further, the phenomenological approach as a whole links nicely to the humanism espoused in the values of many health care professionals. As Reed (1993) has argued, research methods in occupational therapy should be compatible with our organismic and humanistic philosophy. Similarly, Omery noted that the nursing profession "is proud of its identification as a humanistic discipline. The professions' values and beliefs include a view that the human phenomenon is holistic and meaningful. The phenomenological methods share such values and beliefs" (1983, p.62). In view of such compatibilities my attraction, as a therapist, to phenomenology is not surprising.



## Aims of research

The literature review has mapped the territory I wished to cover in my own research, with its focus on the experience of being a professional and doing occupational therapy, and its utilisation of a phenomenological approach. The review has also highlighted some lacunae in the literature - gaps which I have sought to address :

- 1) I aim to explore the **experience of being an occupational therapist**. I start from the assumption that the experience of being an occupational therapist is a phenomenon in itself - that there is some common experience that links the individuals practising in different areas. This is in contrast to much of the literature which investigates specialist areas of practice (e.g. community mental health occupational therapy).
- 2) Whilst there is much exploration of role boundaries and descriptions of actual clinical work undertaken, these studies have largely taken an outsider perspective. I am looking to adopt an **insider view** which includes drawing explicitly on my own experiences.
- 3) I seek to understand more of **how actual day-to-day practice is experienced**. My focus is on what it feels like to be an occupational therapist, not on the rhetoric of what occupational therapy sets out to be. Here, I aim to capture the ambivalences, confusions and tensions of practice rather than the certainties.
- 4) I aim to represent more of the '**subjective**' **dimension** of being a therapist. Most of the current literature has focused on clinical reasoning. The cognitive bias of



much of this work has marginalised emotional responses. I would like to understand more about what the therapists feel and how they cope.

- 5) I intend to study therapists **practising in the United Kingdom**. Much of the current phenomenological literature in occupational therapy relates to practitioners in the United States. The research available on practice in the United Kingdom relates more broadly to other health professionals and I would like to extend this pool to encompass occupational therapists.
- 6) I seek to express something of the **therapist's life world**, taking into account the different phenomenological aspects of identity, embodiedness, sociality, temporality and spatiality. I seek to describe something of the 'whole' experience rather than homing in on specific dimensions like clinical reasoning.
- 7) Finally, in addition to exploring the essential features of the life world, I aim to gain an understanding of **individual therapists'** own meanings. Through tapping into the richness of participants' responses I hope to deepen my understanding of their unique experiences. Much of the existing research offers general experiences, for example, of 'caring'. What is lost is the differences in individuals' meanings, such as how differently the individuals perceive and enact caring. As Jarman et al (1997) notes, "The consideration of the individuality of therapists and their differential influences upon, and experiences of, the treatment process therefore seems an essential component of a clinically meaningful research strategy" (1997, p.150).



## **2.6 REFLECTIONS ON DOING THE LITERATURE REVIEW**

### **Reflecting on the process**

In a sense, my literature review has been an ongoing feature, present throughout my research. Perhaps it is more accurate to say I have engaged in several different reviews. I began with a fairly good grasp of the available literature on occupational therapy. For this reason, my early literature searches focused on methodology, as I tried to learn about phenomenology and soak up what I could about method/findings from other research projects. I kept a watching brief on occupational therapy literature to check if anyone was writing in my area. But mostly I left the substantial review until after my data analysis (to minimise presuppositions). Although I tried to bracket the occupational therapy literature during the data collection/analysis stages, I could not help but be aware of some of it, in particular all the professional navel-gazing material on role.

Overall, I enjoyed doing the literature review. I enjoyed playing detective and following up leads. I also enjoyed the sense of being an explorer with the task of charting new territory and feeling excitement when I found a relevant article.

Sometimes I would feel swamped, overwhelmed with the quantity and richness of the material. How could I begin to make sense of it all? There was just so much to read, to learn! It seemed that I could just get lost in it all and never come back - it was tempting to just keep on reviewing, keep on learning. At these times I would have to discipline myself to get back to a more focused track. I would have to reconcile myself to being selective and to accepting there are many worlds which will remain unexplored. I had to remind myself that the literature review was only a small part of



my research. I had to resist the constant feeling that I needed to do more, that I was missing key material, that if I looked a bit longer I would find the 'answer'.

I have been continually struck by the enormity of my task. The limited phenomenological material available meant that I had to look further afield.

Although little had been written on the 'life world', much of the literature (both qualitative and quantitative) seemed to express relevant dimensions. As my research tackles the whole sense of being a therapist, my review needed to be broad, too. It was challenging to attempt this breadth and yet still manage to get some depth.

I remain concerned that I have cited so many references to small-scale research projects which on their own do not stand up to much scrutiny. However it seemed to me that a bigger pattern could emerge by combining several small studies. Perhaps I have gone overboard with the quantity of references; was this a correct strategy given the trade-off against critical evaluation? Whilst I recognise the limitations of some of the studies, I am also glad to have given voice to infrequently referenced occupational therapy material. It would have been possible to focus on better known literature from the fields of medicine, nursing and sociology. In not doing so I feel I have affirmed the growing academic status of occupational therapy research.

## **Reflecting on the outcome**

Reflecting on the review as a whole I am aware of both the limitations and strengths of the research found. Much of the material on what it is like to be a professional



fails to capture the dilemmas, ambivalences and ambiguities of practice. For instance, the ability of therapists both to love occupational therapy and not know what it means, is rarely captured in the *same* article. Much that is published echoes the accepted professional rhetoric - for example, that occupational therapists 'care'. Little seems to be written about the real world experience of not caring and how we dislike some of our patients. Sometimes heavier, more complex dynamics are explored, for instance professionals' use of defence mechanisms or the use/abuse of power, but even these can fail to reflect what 'real life' feels like. While the literature quite comprehensively explores professional power, it has little to say about patients' power where professionals are abused. Every physiotherapist I have talked to on this subject admits to having been assaulted by at least one patient. I cannot find one reference to this in their literature!

The patchy quality of some of the phenomenological research is also rather disappointing. There is some excellent research on experiences of health/illness, but much less is available on being a professional. But even where some attempt has been made to focus on this, the results have sometimes proved disappointing. To give one example of this, I pounced on an article entitled, 'A phenomenological investigation into the role of the clinical nurse specialist' (Bousfield 1997). While the piece had some interesting points to make about feelings of isolation and disempowerment, there was no exploration of these as themes. Further the voice of the participants (in the form of quotes) was missing entirely. The lack of methodological evaluation further compounded my negative impression.

However, I did come across a number of quality papers and good examples of phenomenological research. Those relating to occupational therapy were particularly



pleasing. Perhaps the high standard in the occupational therapy literature is a product of phenomenology still being a new methodology; the few papers published so far have been written by respected 'experts'. Will standards drop once phenomenology becomes embraced more widely? My guess is that confusions may well increase as contradictory 'models' are offered. However, more research and more debate, in whatever form, is surely a healthy development.

Finally, I have sought to keep a careful eye on the degree to which my research is being superseded by other research. In common with every other researcher, I was fearful lest someone else carry out and publish 'my' research. I remain reassured that this has not happened, although I did have a few moments of doubt that the phenomenological research by Hasselkus and Dickie (1994) and Mattingly and Fleming (1994) may have made mine redundant. However, on a closer reading I decided I need not worry too much. Firstly, they were researching therapists in the United States whereas I was looking at practice in Britain. Secondly, they were focusing specifically on satisfying and dissatisfying dimensions and analysing clinical reasoning narratives, whilst I was attempting a broader life world analysis. Thirdly, their use of questionnaires, telephone interviews and video taped treatment sessions contrasted with my use of face-to-face interviews and participant observation; the results were almost certain to be qualitatively different. I am pleased to have been able to use their excellent research to better inform mine.



### 3. METHODOLOGY

#### 3.1 INTRODUCTION

All my knowledge of the world, even my scientific knowledge, is gained from my own particular point of view, or from some experience of the world without which the symbols of science would be meaningless. The whole universe of science is built upon the world as directly experienced, and if we want to subject science itself to rigorous scrutiny and arrive at a precise assessment of its meaning and scope, we must begin by reawakening the basic experience of the world of which science is the second-order expression.

(Merleau-Ponty, 1962, p. viii)

Thus Merleau-Ponty sets out his stall for a phenomenological science which starts from our basic experience of the world. Such a philosophy carries implications for research method; it requires a method which aims to describe, rather than explain, the human life world.

This methodology section sets out to explore these issues related to philosophy and method. It comprises three parts :

- Section 3.2 'Philosophical and methodological choices' spells out my methodological commitments and their implications for research in practice.
- Section 3.3 'Research design and method' details the actual steps taken in my research.
- Section 3.4 'Reflections on the journey towards a methodology' offers a personal account of how the methodology, and my understanding of it, evolved.



### 3.2 PHILOSOPHICAL AND METHODOLOGICAL CHOICES

A multitude of philosophical and methodological dilemmas confront researchers as we commence research. Underlying every study are explicit and implicit beliefs, assumptions and commitments about the world (particularly the social world) and how we should study it. First, there is the question of *ontology*. What is the nature of our being (and is there only one kind) - and especially, what is the nature of human being? Closely linked to these questions are the *epistemological* debates about knowledge and the relationship between the knower and the known. What can be known? How much of a gap exists between the subject and the object? Then we are faced with a gamut of *methodological* decisions about how to go about our study. Do quantitative or qualitative methods offer a more appropriate approach towards studying the social world? Which particular strategies, theories and methods should we adopt? There are no easy answers to these weighty questions, but it is possible to place them into the context of current methodological debates, namely : a) the debates between the positivist versus interpretivist paradigms (see Figure 3.1) and b) quantitative versus qualitative approaches.

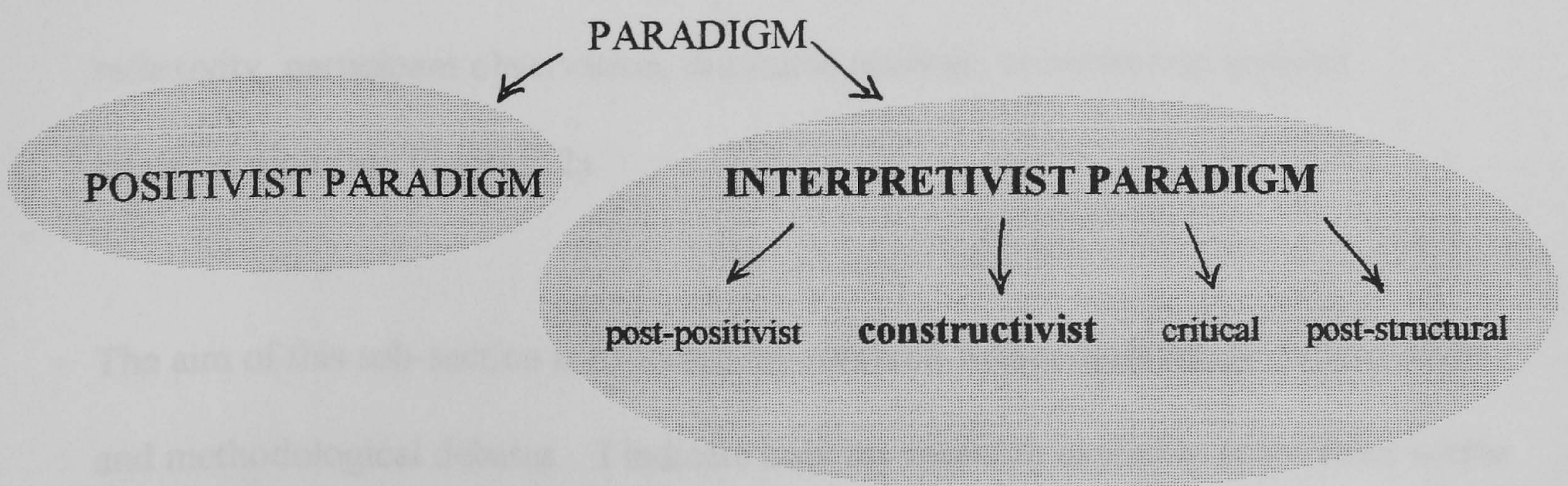


Figure 3.1 : Map of philosophical and methodological field



One problem with attempting any map of competing theoretical perspectives is that different authors/researchers construct different maps. They also vary in their use of terminology. What is a 'paradigm' to one researcher is approach/strategy/philosophy/theory for others. For the sake of both clarity and simplicity, what follows is my construction (derived from my readings of authors such as Denzin and Lincoln 1994). I take two basic paradigms as my starting point : positivism and interpretivism. The latter I then break down into further competing sub-paradigms, namely, post-positivist, constructivist, critical and post-structuralist.

Within the interpretivist paradigm it is possible to take either quantitative or qualitative approaches to research. Whilst the post-positivist and critical sub-paradigms draw on both approaches, the constructivist and post-structuralist sub-paradigms favour qualitative approaches.

In considering qualitative approaches more specifically, different theories inform the choice of particular research strategies and methods. For instance, the theoretical perspectives of phenomenology, hermeneutics, symbolic interactionism, social constructionism, ethnomethodology and psychodynamics each spawn different research methods - respectively phenomenological reduction and description, reflexivity, participant observation, discourse analysis, conversation analysis, interpretation (see Figure 3.2).

The aim of this sub-section is to locate my research within these larger philosophical and methodological debates. I indicate how my research explicitly arises from within the interpretivist, constructivist sub-paradigms and draws on social constructionism,



phenomenology and hermeneutics for its research approach/strategy (see the sections of Figures 3.1 and 3.2 in bold). These theoretical underpinnings carry with them a number of implications for research method ethics, analysis and evaluation and these are discussed in the final sub-section.

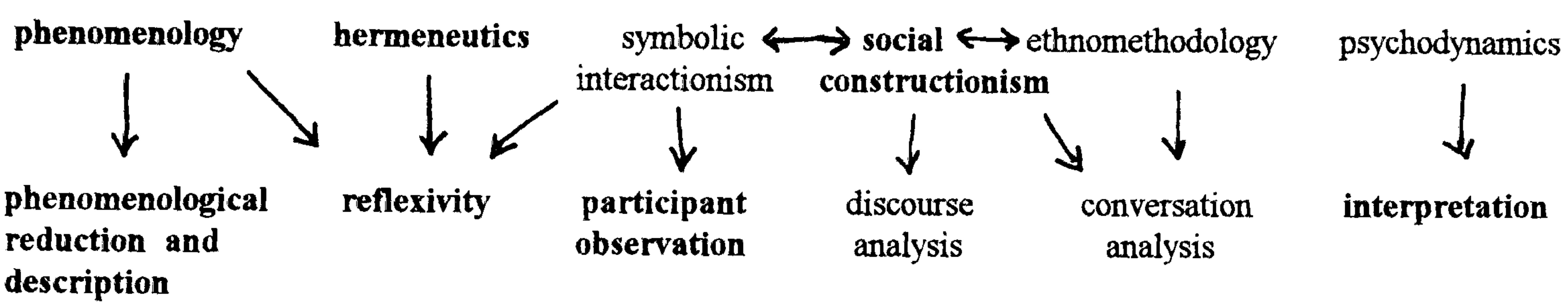


Figure 3.2 Theoretical perspectives and some associated qualitative methods

**The interpretivist paradigm**

Interpretivism stems largely from the German intellectual traditions of phenomenology, hermeneutics and the *Verstehen* approaches to sociology. Interpretivists argue for the uniqueness of human inquiry. They hold that mental/cultural sciences are different from natural sciences in that the goal is to grasp the meanings of social phenomena as opposed to scientific explanation (Schwandt 1994).

My research arises explicitly out of this interpretivist paradigm with its supporting tenets of naturalism, relativism and constructivism (Denzin and Lincoln 1994). I argue that the positivist paradigm, with its search for universal laws which account for causal relationships, is less appropriate for my research as it does not attend sufficiently to differences between individuals’ meanings and the socially constructed nature of our dynamic, multi-faceted world.



Instead, my research is underpinned by assumptions arising from three theoretical perspectives, namely : social constructionism, phenomenology and hermeneutics (see Figure 3.2). These philosophies have guided my research methodology (see Table 3.1) in that : a) I have broadly adopted a social constructionist frame of reference; b) I am committed to phenomenological description and using phenomenological research methods; and c) I have aimed to capture hermeneutic understanding. Each of these points will be explored briefly in turn as I indicate how these ideas have influenced my research methodology.

	SOCIAL CONSTRUCTIONISM	PHENOMENOLOGICAL DESCRIPTION AND METHOD	HERMENEUTIC UNDERSTANDING
MAIN PRINCIPLES	<ul style="list-style-type: none"><li>• constructionism</li><li>• significance of social context</li><li>• importance of language</li></ul>	<ul style="list-style-type: none"><li>• focus on life world</li><li>• commitment to description over explanation</li><li>• use of phenomenological reduction</li><li>• attempt to retain non-judgemental attitude</li></ul>	<ul style="list-style-type: none"><li>• focus on meanings and interpretation</li><li>• fusion of subject-object</li><li>• need to move back and forth in a dialectic between pre-understandings, interpretations and sources of information</li></ul>
IMPLICATIONS FOR RESEARCH APPROACH	<ul style="list-style-type: none"><li>• need to recognise contingent nature of social world and multiple realities</li><li>• recognition of the participant's social life world</li><li>• emphasis on how data collected is product of relationship</li><li>• recognition of importance of language in revealing, even constituting, meanings</li></ul>	<ul style="list-style-type: none"><li>• need to focus and reflect on the participant's life world</li><li>• need to stay with description and resist the temptation to stray into explanation</li><li>• accept participant's expressions in their own terms assuming these are rational and reflect their perceptions</li></ul>	<ul style="list-style-type: none"><li>• meanings central focus which can only be accessed by interpretation</li><li>• recognition of how my own presuppositions and perceptions are central to any understanding gained</li><li>• I need to be actively involved and engaged in research</li><li>• need to move back and forth between the parts and the whole.</li></ul>

Table 3.1 Summary of three perspectives and their implications for my research approach



## Social Constructionist Frame of Reference

Social constructionism (Gergen 1985) focuses on the world of inter-subjectivity and shared social constructions of meaning, as opposed to a more narrow focus on individuals' minds/cognitions. As Gergen and Gergen explain, "Accounts of the world...are not viewed as the external expression of the speaker's internal processes...but as an expression of relationships among persons" (1991, p.78).

Emphasis is placed on the collective creation of meaning as shaped by language, ideology and other social processes occurring in particular social contexts. The theory can be understood in terms of three main principles :

- constructionism
- the significance of the social context
- the importance of language.

### Constructionism

Constructionism starts from the interpretivist position that in order to understand a world of meaning we must interpret. Constructionists assert that we actively construe our world; they challenge the concept of independent reality and knowledge reflecting a fixed world. Instead, they are deeply committed to the idea that truth/knowledge is the result of perspective. It is created, not discovered, by the mind (Schwandt 1994).

Thus, a relativist position is adopted where individuals (within their different sub-cultures) are seen to understand the world in different ways. Post-modern, post-structural versions of constructionism adopt the more radical relativist position that reality is only that which is represented by a multiplicity of voices and interpreted texts.



As Bruner asserts, “contrary to common-sense, there is no unique ‘real world’ that pre-exists and is independent of human mental activity and human symbolic language” (Bruner 1986, p.95).

I loosely adopt this perspective as a broad framework for my research as I recognise the multiple, contingent nature of our understandings of the world. Reality is not one thing - instead it is impregnated with different social meanings. Different individuals (who are set within different cultures) enact different practices so they experience different realities as well as different social contexts shaping their practice. I have endeavoured to capture and stress these points in my findings.

### Significance of the social context

Social constructionists argue that the boundaries of a ‘person’ are intertwined with those of their social context. The self (a person with a mind, consciousness, identity and body) is seen as essentially a social being - a product of a social world consisting of social structures, divisions, interactions, practices. Individuals are seen as both actively constructing their world and being constructed by their world. As Bruner suggests, the self is best understood as ‘the sum and swarm of participations in social life’ (cited in Wetherell and Maybin 1996, p.223).

My focus has been on understanding individual experience, but for me the social context of such experience is an ever present feature. Firstly, I recognise that the individual’s life world is always tied to social relationships and understandings. Secondly, in my use of participant observation as a research method, I sought to see occupational therapists interacting with others within their actual social world.



Thirdly, I emphasise how my data collection/analysis is a product of the social context of the research (namely, a product of my relationship with the participants).

### Importance of language

Finally, social constructionists argue that language is not a transparent medium of communication but actually constructs our thinking about the world in the course of its use. As Rorty (1979) argues, conversation can be seen as "the ultimate context within which knowledge is understood" (cited in Kvale 1996, p.37). Moreover, the use of discourse within society shapes the way the world is perceived and experienced because of the different ideological messages contained within the language.

"Conversation is not just one of our many activities in the world. On the contrary, we constitute both ourselves and our worlds in our conversational activity" (Shotter 1993, cited in Kvale 1996, p.37).

As conversations and texts can be understood to reveal something about both the individual and their social world, I have chosen to use interview as my prime method of data collection. Further, although I have not engaged in discourse analysis, I have emphasised the power of language and how certain words or terms (like 'caring' or different medical diagnoses) carry significant meanings. Thus, I retain my basic commitment to phenomenological thinking in that I see any talk as being about the life world.



## Phenomenological Description

Phenomenology is the attempt to describe individuals' experience. It also seeks to move beyond appearance to grasp underlying, essential meanings. As Kvale puts it, phenomenology attempts to go beyond "immediately experienced meanings in order to articulate the pre-reflective level of lived meanings, to make the invisible visible" (1996, p.53).

Phenomenological philosophy was largely developed by Husserl in the late 19<sup>th</sup> Century to study phenomena as they appear through consciousness. He aimed to clarify general structures/essences of consciousness towards building a theory of the phenomena concerned. Subsequent theorists have taken phenomenology in different directions, aiming to discover the world as it is lived and experienced. For instance, Heidegger's hermeneutics, Merleau-Ponty's existential phenomenology and Shutz's social phenomenology all offer a distinct focus. Each of these theories seek different understandings and are therefore operationalised differently in research.

However, five common principles seem to underlie all these variants of phenomenology to a greater or lesser degree :

- i. a focus on the life world or *Lebenswelt*
- ii. the concept of intentionality
- iii. a commitment to description over explanation
- iv. the use of phenomenological reduction and *Epoche*
- v. an attempt to retain a non-judgemental attitude



My research stems largely from Husserl's (1970) later work, where he elaborated the notion of the life world - a notion which was subsequently taken in an existential direction by Merleau-Ponty and Heidegger.

### The life world - *Lebenswelt*

The life world is the world of experience as it is lived. We each live in a 'reality' which is : a) the world of objects around us as we perceive them; and b) our experience of our self, body and relationships. The idea of life world is that we exist in a day-to-day world that is filled with complex meanings which form the backdrop of our everyday actions and interactions.

Phenomenological theorists posit there are certain essential features of any life world, namely identity, embodiedness, sociality, temporality, spatiality. The task of the researcher is to bring these out. In existential terms the life world of an individual can be understood as comprising three universal horizons of experience :

- being a body in space (*Umwelt*)
- being a self in time (*Eigenwelt*)
- living with others (*Mitwelt*)

Mattingly and Fleming (1994) suggest that occupational therapists implicitly understand these concepts of the life world as occupational therapy aims to enable patients/clients re-enter a life world after illness or injury. Therapists "actively help people struggle with the personal and social meanings that accompany the difficult transition back to the life-world, now that one has a changed body and, usually a changed self-image and social position" (Fleming 1994b, p.100).



In my research I aim to bring out the essential features of the life world in so far as they are seen to illuminate the occupational therapist's situation. The aim of the research is to attempt to describe how the occupational therapists engage with their life world and identify their perceptions of their reality of what it is like to be an occupational therapist. It is assumed I might be able to express their life world more tellingly than they would themselves, as they live through rather than reflect on their world, whereas I have both experienced and reflected on what it means to be an occupational therapist. Thus my focus follows the emphasis of Heidegger and Merleau-Ponty's existential work and moves away from Husserl's focus on consciousness and aims of eidetic study to identify general essences.

### The concept of intentionality

Phenomenologists posit the concept of intentionality. They argue that the life world is not an 'objective' environment or a 'subjective' consciousness or set of beliefs; rather, the world is what we perceive and experience it to be. They assert that objects and subjects cannot be separated as the object means different things to different subjects (i.e. they reject Cartesian notions of subject-object dualism). In a world of meanings/interpretations, there are multiple realities beyond a single reality; any object is more than a physical object as it has significance and meaning as soon as it is perceived. Similarly, a pure subject cannot exist as the subject exists in the world. The subject thinks *of* something, feels *for* others, imagines things about and beyond - and this is the idea of intentionality.



Psathas explains this process in the following terms :

The world is not filled with objects that have appearances independent of humans who experience them, nor does subjective experience exist independently of the objects, events, and activities experienced. There is no pure subjective subject or objective object. Phenomenology recognises that all consciousness is consciousness of something. Intentionality is the term used to refer to this relation. (cited in Crotty 1996, p.46)

Thus, the person and the world are seen as inextricably intertwined; humans actively engage in and with their world. In my research, then, I set out to describe the therapists' experience in a broader way, to focus on the whole life world of the therapist rather than homing in on specific aspects. Rather than simply delving into individuals' subjective feelings, I have sought to understand each person's broader existence. In particular, carrying out participant observation allows me to attend to the social context within which the subject reveals itself.

### Description over explanation

Phenomenology is committed to describing, not explaining, how and why meanings arise. The aim is to understand human experience (*Verstehen*), to gain access to the mind or spirit (*Geist*) of the other person (Dilthey 1990).

The descriptive nature of phenomenology is revealed in three ways. Firstly, the original data consists of naive descriptions (prompted by open-ended questions) of the participant's experience. Secondly, the researcher endeavours to describe the structures of experiences. Thirdly, there is an attempt to present the findings in a descriptive manner (for instance, in the form of descriptive themes combined with direct quotes from the participant).



My research seeks to describe what it is like to be an occupational therapist rather than analyse why occupational therapists are the way they are. In the words of van den Berg, I aim to give "plausible insight" rather than attempt a theory (1972, p.4). I have, therefore, taken care to limit myself to description and offer little in the way of explanation. Only in the discussion section do I suggest some avenues of explanation for possible future research. For instance, for the hospital-based therapists, the hierarchical medical social structure has figured prominently in their stories. My concern has been to recognise the importance to them of such a social structure rather than suggest how it may have shaped their behaviour. It is not until the discussion that I note differences between the hospital and community therapists in terms of their acceptance of medical authority and suggest this may be a product of different values occurring in different work contexts.

### Phenomenological reduction and Epoche

The phenomenological approach rests on the technique of trying to suspend and bracket (i.e. treat differently) any presuppositions, interpretations and prior understandings in order to enter into the world of the unique individual being studied. This is Husserl's notion of epoche where in effect the 'natural attitude' is initially cancelled (Paley 1997). This is necessary in order to attend genuinely and actively to the participant's view. In phenomenological research, preconceived ideas are bracketed initially to enable the researcher to experience the process of discovering the phenomenon firsthand through direct contact or 'intuition'. Husserl named this change from the natural to the philosophical attitude 'phenomenological reduction'. The phenomenological maxim is to let the things themselves be our guide : in Husserlian terms, 'back to things themselves' (cited in Crotty 1996, p.31).



Having acknowledged the ideal of suspending presuppositions, it is also necessary to recognise the impossibility of bracketing everything (or even of bracketing at all). In the words of Merleau-Ponty, “The most important lesson which the reduction teaches us is the impossibility of a complete reduction” (1962, p.xiv). Merleau-Ponty went on to re-interpret Husserl’s work in an existential manner, as a resolve to set aside theories/research presuppositions in order to reveal the lived experience rather than concentrating on detached consciousness (Ashworth 1996a).

In this tradition, then, researchers bracket to reveal the life world in all its ambiguity and try to see the world from another's point of view. In my research I have tried to bracket in a number of ways :

- i. I aim to recognise the assumptions guiding my investigation. For instance, I assume my participants and I share a language and topic (i.e. there is some inter-subjective understanding), that our interaction is meaningful and that they can express something of their life world.
- ii. I have tried to avoid forming prior research hypotheses. In particular I kept an open mind about what I might learn about the life world, if indeed a life world even existed.
- iii. I have attempted to set aside as much of my own understandings (including my occupational therapy knowledge) as possible. I have tried to listen actively, to be open and ask naive questions, like “What do you mean by ADL?”. Although the term ‘ADL’ is standard occupational therapy jargon, I made efforts not to assume a completely shared language despite common professional socialisation.



iv. Then, during analysis, I try to avoid imposing theoretical prejudices and analytical/explanatory categories. Instead I aim, insofar as possible, to allow only the meanings and themes relevant to my participants to emerge.

### Non-judgemental attitude

In the phenomenological approach, the individual's expressions are both accepted (i.e. not morally judged) and valued. The participants are assumed to be rational and to honestly reflect their perceptions. Such a stance implicitly rejects the view that the participants may be deliberately or unconsciously distorting their report, for instance as a result of defence mechanisms (as psychodynamic theorists would suggest) or ideological bias (as critical theorists would say).

Giorgi (1985) links up this non-judgemental attitude with the concept of reduction (and, to some extent, intentionality). He explains how a researcher aims to capture simple, pre-reflective natural descriptions of how a phenomenon is experienced rather than assume it is a reality. In other words the researcher refrains from affirming that what presents itself is what it is. He or she accepts and records what the participants say about their experiences rather than standing in judgement. The 'truth' is in what the participants are saying.

In my research, whilst I accept distortion (from unconscious or ideological bias) may well have occurred, I see this as less relevant than how the person perceives their world. What is important is what they see as being significant. If an individual seems to be defensive, I have aimed to pick up the underlying story - for example, that they may feel threatened in some way. Also, I made efforts to set aside my own emotional



reactions and, at the very least, try not to communicate negative judgements about what the therapists were saying.

## **Hermeneutic Understanding**

Heidegger's (1962) critique of Husserl's work led him to develop his existential-ontological-hermeneutic philosophy. His critique can be summarised in four points :

- i. Heidegger disagreed that 'consciousness' should be the focus and shifted attention to 'being'.
- ii. He argued that object and subject could not be separated.
- iii. He denied Husserl's essentially positivist search for universal eidetic essences.
- iv. He argued against the possibility of bracketing, ruled out by the individual's 'being-in-the-world'.

Heidegger stressed that a person's cultural-social background is always implicitly present. It is this which gives us a pre-understanding on the basis of which we can understand and be in the world. In his own words, "Whenever something is interpreted as something, the interpretation will be founded essentially upon fore-having, fore-sight, and fore-conception. An interpretation is never a presuppositionless apprehending of something presented to us" (1962, p.191). Every encounter is seen to involve our interpretation based on this historicity and our experience. At first we are pre-reflectively in touch with the world, then through engagement we develop an interpretative awareness of it. As Taylor (1987) notes, "We are self-interpreting, self-



defining living always in a cultural environment, inside a web of signification we ourselves have spun. There is no outside, detached standpoint...we are dealing with interpretations and interpretations of interpretations” (cited in Koch 1995, p.831).

Similarly, Gadamer believes that understanding results from a fusion of horizons of interpretation and the object (Warnke 1987). He suggests that a gradual development of knowledge only becomes possible when we continually question our prejudices and amend our assumptions, thereby allowing us to move to richer, more developed understandings. Our understandings are being continually modified as we move back and forth, looking at the whole and parts in a dialectic between pre-understandings, interpretation, sources of information and what is being revealed. This is then re-examined and reinterpreted. This hermeneutic circle is offered as a method of phenomenological study.

Whilst I reject Heidegger’s conservative politics and anti-humanist, anti-rationalist position, my research embodies a commitment to hermeneutic understanding in four main ways :

- i. I have taken meanings as the central focus of my analysis and I assume that these can only be accessed through interpretation.
- ii. I argue that my own foreknowledge, presuppositions and perceptions are fundamental to any understanding I gain and have thus included myself through reflexive analysis.
- iii. I accept that understanding any text or way of life involves my active engagement in the process of encounter and response.
- iv. In my analysis I moved continually back and forth between the parts (phrases/meaning units) and the whole (*gestalt* of the interview).



## **Implications for Method, Ethics, Analysis and Evaluation**

The constructivist, phenomenological methodology described above carries with it a number of implications for the research process in terms of method, ethics, analysis and evaluation procedure. Such a methodology demands a qualitative approach; research methods are geared to accessing individuals' meanings. This then carries ethical implications which need to be addressed. Next, the method of analysis needs to capture phenomenological and hermeneutic understandings (for instance, through using both phenomenological and reflexive analysis). Finally, there are implications for evaluating the research as the 'scientific criteria' of validity and reliability are not compatible with relativist conceptions of a socially constructed world.

Applying these points to my research, this sub-section aims to explore my use of :

- qualitative research methods
- ethical measures
- phenomenological analysis
- reflexive analysis
- criteria for evaluation

### Qualitative research methods

Under the rubric of a qualitative approach, I had a choice of a number of research methods, including interviews, observation, oral history, diary/document analysis, repertory grid, conversation analysis and discourse analysis. In the event, I restricted my choice of method to interviews and participant observation. In part this reflected



my own interests and predilections. But the choice was also bound up with my ambition to maintain a theoretical consistency with phenomenology. Although discourse analysis was of interest to me, it seemed likely to push me in a different direction, into social constructionism and critical theory. For this reason I consistently maintained a commitment to a phenomenological approach to both data collection and analysis.

I chose interview as my primary research method because entering into ‘conversation’ seemed to offer the most direct way to begin to access a person’s meanings. Of course any account of a person’s experience in an interview is retrospective and one step removed from the experience itself. However, such a passage of time may result in a fuller account, with the participant able to reflect on his or her experience and select the most meaningful aspects (Hycner 1985).

As a supplement to the interviews, I carried out some participant observation of occupational therapists working in a physical practice setting. The main value and rationale for this was to get a better feel for the physical therapists, as their practice was relatively unfamiliar to me. It also enabled me to explore any negative judgements about their way of working which I could then attempt to put aside.

Alongside my choice of method, decisions about sampling were influenced by my methodology. As a qualitative researcher I could reject notions of having to study a large, random, representative sample and think more purposively. My sample choices (eleven therapists and four types of health care contexts) evolved with my data collection. I started with one health care context and when it seemed that what I was receiving was becoming repetitive, I moved on to a different setting. I kept the



number of participants low enough to ensure I maintained a depth and specificity of focus (on individuals), but high enough to make possible comparisons across different health care settings.

If in an investigation of human meanings the aim is to capture nuance, ambiguity and rich description rather than causal explanation and precise measurement, then a qualitative approach to analysis is necessary. Thus, in my research, I have pursued an exclusively qualitative analysis, rejecting any attempt to ‘quantify’ (code, measure, count). Giorgi (1994) picks up this point in his critique of ‘mixed discourse’ where he argues there is a logic to qualitative research that guides it from conception to write-up. He asserts that the temptation to combine quantitative measures with a qualitative approach is a misplaced attempt to gain ‘scientific credibility’ and is ultimately inefficient and unhelpful. In my analysis I did not find it relevant to count how many times the word ‘holistic’ was used, but it did seem relevant to explore its significance (even if it was only used once). Equally, I was not trying to establish criteria for what it means to be therapeutic or detail the precise functions of the occupational therapy role. Rather, I sought to explore what therapy meant to each therapist.

In pursuing this insider approach, I felt obliged to recognise my inevitable presence and the role played by my understandings and interpretations. I have, therefore, engaged in both reflexive and phenomenological analysis.

### Ethical measures

When it comes to ethical considerations, adopting a qualitative method of research carries both advantages and disadvantages. On the positive side, qualitative research taps a spirit of openness and sharing, particularly as the participants are invited to act



as co-researchers rather than simply being ‘subjects’ (or even objects) of study. On the negative side, the very research method employed results in relatively high levels of personal disclosure and exposure, prompting questions about invasion of privacy and manipulation on the part of the researcher. Throughout my research I have taken steps to protect my participants and ensure the research experience was reasonably positive. Particular measures were taken in terms of informed consent, confidentiality, protecting the participants and respecting them.

a) Informed consent - Informed consent was obtained throughout the research in several ways:

- i. All the participants agreed (verbally) to be interviewed, recorded and observed as relevant. In several cases I was required to seek written permission from their managers as well.
- ii. Prior to obtaining their consent I had an informal chat with each of them, usually over the telephone, to give them opportunities to query any aspect.
- iii. They all understood that they could withdraw from the research at any time.
- iv. All the participants explicitly consented to be audio-taped when interviewed.

In the participant observation, they all agreed to my note writing and were able to ask me to refrain from doing so at particular moments.

- v. I emphasised that the participants were in charge of their own degree of disclosure. For instance, they could ask for the tape to be switched off or call a halt to a particular line of questioning.

b) Confidentiality - I emphasised that the information obtained from the participants would be confidential (known only to myself and my research supervisors) and that where it was to be published I would guarantee anonymity. This was achieved by



using pseudonyms in my findings, omitting key information which would identify the participant and occasionally including ‘misinformation’ (such as changing the sex of the person). I remain slightly concerned that on occasion other therapists knew when and who I was interviewing, which prejudiced the degree to which I could protect my participants. However, this did not seem to be in my control. None of the participants seemed concerned about this, which was reassuring.

c) Protecting the participants - Throughout my research I have been sincere about trying not to harm my participants. If anything, I have sought to have a positive impact. In particular I have tried to equalise the power dimension underlying our relationship :

- i. In order to actively engage with all my participants, I tried to make warm interpersonal connections and also made it a point to disclose personal information about myself.
- ii. The participants all took some measure of control by choosing where and when the interview took place and how long it lasted.
- iii. During the interviews I continually checked out my perceptions and gave opportunities to the participants to modify or emphasise anything they had said.
- iv. The participants received a full copy of the transcript of the interviews and were invited to comment (an offer none of them in the event took up).
- v. I also offered to share my analysis with all the participants and generally demonstrated an openness about the findings (but again none pursued this).

The two participants who I asked specifically if they would read their analysis seemed comfortable with my integrity in trying to reflect their perspective.



- vi. I endeavoured to leave my participants feeling positive about the research process and confident that they have made a valuable contribution. Many of the participants indicated that they had enjoyed the experience of being interviewed and that it had made them think.

Despite the above measures I remain aware that complete consent, confidentiality, mutuality and equality did not occur. For instance, I was not always specific about my research aims and method (for instance I did not reveal my particular interest in their views of patients and clients). Also I did not share my personal reflections and reflexive analysis - a point which emphasises the limits to my apparent openness. Ultimately, some power imbalance remained as I was the one asking questions and they were being 'enabled' (by me) to reveal personal, sometimes painful, details.

### Phenomenological analysis

Two principles underpin any method of phenomenological analysis :

- i. It needs to be discovery-orientated, aiming for description rather than speculation or explanation.
- ii. The method adopted should arise out of the data and be responsive to the phenomena. No method should be imposed arbitrarily as that would do an injustice to the phenomena under study (Giorgi 1971a).

I have attempted to follow these principles in my use of particular techniques of phenomenological analysis. My chosen method of analysis, described below, is based largely on the one developed by Wertz (1983) following Giorgi's (1975a,b) general outline. The analysis is broken down into two distinct phases : i. analysis of the



individual; ii. analysis of the general. Each of these phases involves a number of different tasks which are worked through, but not necessarily in any fixed, defined sequence. These stages and tasks are summarised below.

In applying these steps to my research, it is worth stressing that although the steps appear sequential, the actual analysis undertaken was more fluid, spontaneous and intuitive. As Wertz notes, insights often occur as a “spontaneous upsurge of a largely intuitive character rather than any deliberate following of explicit rules” (1983, p.198). The steps frequently converged, and in the different individual analyses certain tasks took on more importance than others. In a way the steps specified below are better understood as guidelines for an appropriately phenomenological attitude.

*Analysis of the individual :*

1. **Empathic immersion in the world of description** - The researcher starts by immersing himself/herself in the tape or transcript, repeatedly listening to the participant’s description of their world. The researcher aims to empathise, to ‘feel’ the participant’s situation. Care is taken to gain a sense of the whole - a *gestalt* - by listening to both the verbal and non-verbal/paralinguistic communications.
2. **Delineating units of meaning** - The researcher engages in a rigorous process of dividing the transcript into phrases or meaning units to allow a focus on the content.
3. **Slowing down and dwelling** - The researcher makes room and takes time for the description, focusing on selected chunks of the meaning units to begin to divine what certain aspects mean to the participant. Care is taken to stay with the data, and even the literal words, rather than jump into premature analysis.



4. **Magnification and amplification** - When the researcher lingers over what seems to be a meaningful excerpt, its significance is brought to the fore and probed further.
5. **Suspension of belief and employment of intense interest** - The researcher takes a step back and begins to think interestedly about where the participant is, how he/she got there, what it means to be there, and so on. Connections start to be made.
6. **Turning towards meanings** - The researcher focuses on the way the situation appears to the participant and what objects or events mean to them (i.e. the researcher refrains from judging the 'truth' of the situation).
7. **Reflection** - The researcher probes more deeply, for instance : a) penetrating implicit horizons (i.e. things not said); b) dwelling on contradictory, vague and opaque aspects; c) seeing relationships between themes; d) using imaginative variation to determine essential characteristics (what Goffman calls 'negatively eventful' occasions) such as asking 'What if...?' or envisaging a scenario played out over time.
8. **Focusing on existential dimensions** - The researcher tries to become aware of existential dimensions of identity, sociality, corporeality, spatiality and temporality. But he or she does not artificially impose them.
9. **Languaging** - The researcher puts a name to themes, phases, relationships, and distinctions, using his/her own words to seek to capture the 'life world'.
10. **Verification and reformulation** - The researcher constantly returns to the original description to try to stay 'true' to the phenomenon and modifies or elaborates themes/sub-themes accordingly. At this point the researcher resists 'packaging' the themes too neatly; instead, incomplete, ambiguous or contradictory data is prized.



*Analysis of the general :*

1. **Seeing general insights in individual structures** - The researcher critically considers which features of the individual analyses might manifest a general ‘truth’ and which features refer to the particular case.
2. **Comparison of individual descriptions** - The researcher compares the analyses across all the individual studies to establish commonalities and differences.
3. **Imaginative variation** - The researcher imagines different possibilities to establish the limits of any general statements (in other words, to challenge claims to universality). A sense of a hierarchy of the individuality versus generality of the themes emerges.
4. **Explicit formulation of generality** - The researcher languages the general truths, i.e. establishes essential themes/structures whilst also giving voice to individual differences.
5. **Verification and reformulation** - The researcher modifies or elaborates themes/sub-themes as required.
6. **Turning to expression** - At this final stage, the researcher aims to utilise language in a way that resonates and brings to life the flavour of the phenomenological experience (for example through the use of imagery or metaphor). As Van Manen puts it, “the researcher is an author who writes from the midst of life experience where meanings resonate and reverberate with reflective being. The researcher as author is challenged to construct a phenomenological text that possess concreteness, evocativeness, intensity, tone, and epiphany” (1997, p.368).



Engaging in phenomenological analysis, then, is a complex process. It is both a logical procedure and an exercise in creativity; the researcher is simultaneously intensely involved and analytically distant. This process requires the researcher to be aware of and reflect on his or her role when analysing the data. This is the key function of reflexive analysis - an additional level of analysis which is explored more fully in the following section.

### Reflexive analysis

Qualitative researchers argue that with their type of investigation the researcher is a central figure who influences the collection, selection and interpretation of data. His/her behaviour will always affect participants' responses, thereby influencing the direction of findings. They further argue that meanings are negotiated between the researcher and researched in a particular social context - another researcher in a different relationship will unfold a different story.

In order to evaluate how subjective and inter-subjective elements have impinged on my research process, I have attempted both personal 'reflection' and systematic, dialectical 'reflexive' analysis<sup>1</sup>. So, *reflexivity* (or 'disciplined reflection' as Wilkinson 1988 calls it) has come to be embraced as one of my research tools.

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<sup>1</sup> Reflection can be understood as 'thinking about'. As a subject I can reflect upon an object and some distance is created here as it takes place after the event. This is quite different from phenomenologists' notion of the pre-reflective condition which takes place during the lived experience. With pre-reflection subjects and objects are enmeshed in existence. Reflexivity involves a process of meta-analysis where the researcher tries to capture some connections of how the subject interprets or influences the object and vice versa.



**Theoretical underpinnings of reflexivity** - The principles of phenomenology, social constructionism and psychodynamic theories provide justification for the use of reflexive analysis.

*Phenomenologists* start with the proposition that each researcher will perceive the same phenomenon in a different way; each person brings to bear his or her specific understandings and background. Heidegger, for instance, suggests researchers interpret according to their own lived experience and historicity. This ‘being-in-the-world’ means that they need to bring their own involvement/fore-understandings explicitly into the research. Understanding results from a dialectic between the researcher’s pre-understandings and the research process; between the self-interpreted constructions of the researcher and those of the participant.

Phenomenologists argue that we need to look within in order to attempt to disentangle our perceptions/interpretations from the phenomenon being studied. For instance, in my research, I needed to attempt to isolate my own experience of being an occupational therapist in order to focus on and capture my participants’ experience. At the same time I needed to recognise that whatever understanding I gained was only possible because of my particular experience.

What philosophical phenomenologists emphasise is the need to reflexively interrogate our subjectivity as part of investigating how the ‘subject’ is present in the ‘object’. In Gadamerian terms, reflexivity involves a positive evaluation of the researcher’s own experience in order to understand something of the fusion of horizons between subject and object (Outhwaite 1985). “For phenomenology”, comments Giorgi, “nothing can be accomplished without subjectivity, so its elimination is not the solution. Rather how



the subject is present is what matters, and objectivity itself is an achievement of subjectivity” (1994, p.205).

*Social constructionists* draw on the notion of reflexivity to explain how individuals make sense of the social world and their place in it. Three different strands of argument about the social dimension of reflexivity can be pulled out :

- i. Mead (1934), writing from a symbolic interactionist perspective, considers reflexivity central to becoming a person. He argues that individuals gain self-awareness in and through interactions with others.
- ii. Giddens (1991), following Har  e's (1983) notion of 'identity projects', argues that identity has become a reflexive project in our post-modern (or late modern) age. He discusses how the construction of self is turned to as a source of both interest and meaning.
- iii. Taking a somewhat different line, Habermas focuses on the capacity of humans to be reflexive agents and how through reflecting on our own history (as individuals and as members of larger societies) we can change the course of history. Habermas argues that the more we can understand how structural forces shape us, the more we can escape from those constraints (Giddens 1985).

In contrast to phenomenologists, social constructionists argue against the inward approach of subjectivity where individuals are engaged in “looking back at themselves in an infinite regress of cognitive dispositions” (Gergen and Gergen 1991, p.79).

Social constructionists instead invite the researcher to look outward into the realm of interaction, discourse and shared meanings. In terms of my research, both my participants and myself share a culture and language based on our occupational therapy



experience. Our professional socialisation is sufficiently similar to allow me to understand many of their meanings.

Social constructionists also emphasise that any qualitative research is a co-constituted account. They argue the need to explore the dynamics of the researcher-researched relationship as this fundamentally shapes research results. Another researcher than the one involved will, they say, have a different relationship, responding differently, asking different questions and prompting different replies. Thus reflexive analysis is necessary to examine the impact of the researcher and participants on each other and on the research. This is a complex undertaking; the distinction between the ‘observer’ and ‘observed’ is problematic given their “emerging relatedness in the interview situation as each observes the other observing” (Jorgenson 1991, p.210).

As part of their concept of research as a co-constituted account, social constructionists argue that the research participants also have the capacity to be reflexive beings : they can be co-opted into the research as co-researchers. The research process itself becomes a negotiated reflexive dialogue where both the researcher and participant are equally engaged in analysis. Smith (1994) cites an example of how utilising the participants' interpretations resulted in the researcher confronting, modifying and honing his own interpretations. This type of co-operative inquiry approach can be seen to operate in a broad range of methodologies, from humanistic new paradigm research (e.g. Reason 1988) to more sociological feminist and discourse analysis research (e.g. Wilkinson 1988).

The focus and interest of *psychodynamic theorists* shifts to exploring how unconscious processes structure relations between the researcher, the participants and the data



gathered. They recommend the use of both introspection and self-reflection (embracing a variety of psychoanalytic techniques such as dream analysis and interpretation of fantasies) as research tools to enable researchers to become aware of the emotional investment they have in the research concerned. Such reflections are further assumed to provide data regarding the social/emotional world of the participant (Hunt 1989).

Psychodynamic theorists emphasise the need for us to explore how conversation or text affects us and to reflect on what we bring to it ourselves. In particular, they point to how unconscious needs and transferences structure the relationship between researcher and participant. Equally the participant's transferences are seen to impact on the stories they tell. Hunt (1989) provides an illustration of why the researcher might experience feelings of helplessness, loneliness and alienation in the early stages of fieldwork. She recommends reflecting on possible links with past experience, such as relating the culture shock experienced as a 'outsider' to the childhood experience of the birth of a younger sibling.

**Applying reflexivity in practice** - Reflexivity, then, can be understood in a multitude of ways. It can be understood as reflecting on one's own personal reactions or unconscious needs. It can also mean reflecting on the dynamics of the researcher-researched relationship and how the research is co-constituted. In practice it has been applied at different levels. At the simplest level, it can mean acknowledging the existence of researcher 'bias' and reactivity effects. Alternatively, it can mean that subjectivity is embraced more fully (as I have done in my research) - for example, by engaging in explicit reflexive analysis throughout the research process.



<u>type of reflexivity</u>	<u>focus/aim</u>
Personal reflexivity	To examine personal responses in order to gain insight into others
Social reflexivity	To explore how meanings are negotiated in a social context given the dynamics of researcher-researched relationship
Methodological reflexivity	To critically evaluate how the researcher's perspective impacts on both data collection and analysis

Table 3.2     Three types of reflexivity

One way of reconciling the diverse approaches to reflexivity is to argue that reflexivity needs to occur at different levels - personal, social and methodological. Here, I offer a novel way of conceptualising reflexivity as three distinct, but interlinked forms which carry different implications for research practice (see Table 3.2). Applying these ideas in my reflexive analysis (see section 4.3) I attempt to evaluate : a) my subjective responses (*personal reflexivity*); b) the dynamics of the relationship between myself and my participants (*social reflexivity*); and c) my method of research (*methodological reflexivity*).

Criteria for evaluation

Rejecting positivism in favour of interpretivism implies that we also have to reject positivist conceptions of reliability and validity. Firstly, reliability (i.e. the inner consistency of the means of data collection) is largely irrelevant because qualitative research, by definition, does not seek to repeat the research or gain consistent accounts; a participant's responses are elicited within a specific and interpersonal context so cannot be replicated (Finlay 1998). Further, as Kvale (1996) notes, while



reliability of interview findings is desirable to counteract haphazard subjectivity, an undue emphasis can counteract innovation.

Secondly, validity is concerned with providing evidence that the research corresponds to some 'reality' - an inappropriate notion, as in the human social world we cannot assume one unequivocal reality to which all findings must respond. Similarly, goals of generalisability are unachievable as single case studies cannot be representative of the whole population.

Although these traditional criteria for evaluation can be rejected, the quality of research can still be judged. New and different criteria, specifically responsive to qualitative research ideals, are necessary to ensure the integrity and justifiability of the research. Guba and Lincoln (1996) argue for two sets of criteria to judge the quality of any investigation : trustworthiness and authenticity. Trustworthiness is seen to embrace criteria of credibility, transferability and dependability (paralleling positivist criteria of internal validity, external validity and objectivity). Authenticity relates to the degree to which the research empowers and enhances growth, understanding and future action.

Opting for a more committed social constructionist interpretation of validity, Kvale (1996) suggests a number of approaches to judging the quality of findings. Ashworth (1996b) summarises these in terms of four key criteria :

- i. Internal coherence - Is the description of the participant's life world clear and coherent?
- ii. Defensibility - Can the research show attempts to adduce evidence which run counter to findings (an idea not dissimilar from Popper's falsifiability criterion)?



- iii. Pragmatic truth - Do the findings match the evidence and can they be shown to lead to a usable framework for action?
- iv. Communicative truth - Given that meanings are elicited in an interpersonal context, have the knowledge claims been tested and argued in dialogue with others (for instance with the participants or within the academic community)?

The common message from these different criteria for evaluating the quality of research is that it is necessary to argue for (rather than prove) integrity by systematically justifying claims. In my research, this has been attempted in three particular ways : reflexive introspection; documented evidence; and communicative validation. Each of these is briefly (though not uncritically) discussed below.

**Reflexive introspection** - I have argued that the quality and integrity of any research can be undermined if both subjective and inter-subjective dynamics are not explored explicitly (Finlay 1998). Researchers' thinking needs to be fully acknowledged and revealed because they are part of the world they are studying.

Reflection and reflexive analysis (particularly methodological reflexivity) have therefore been my primary evaluation tools. I have used them to try to probe the influence of my thinking and responses and to lay the research process open to public scrutiny. In addition, my systematic use of reflection provides a public log of my methodological assumptions and decisions. Whilst such analysis does not 'prove' anything, I believe it demonstrates a preparedness to engage in careful, systematic, in-depth analysis. It also indicates a level of 'moral integrity'. As Kvale (1996) notes : "Validity is not only a matter of the methods used...the researcher...including his or



her moral integrity...is critical for evaluation of the quality of scientific knowledge produced." (1996, pp. 241-242).

**Documented evidence** - Documented evidence includes providing examples of behaviour and direct quotes. The process of building comprehensive documents is important as it opens up the research to external audit. The goal is to back up interpretations sufficiently to enable others to confirm the plausibility of the analysis. As Kvale (1996) argues : "Ideally, the quality of the craftsmanship results in products with knowledge claims that are so powerful and convincing in their own right that they, so to say, carry the validation with them, like a strong piece of art. In such cases, the research procedures would be transparent and the results evident, and the conclusions of a study intrinsically convincing as true" (1996, p.252).

In my write-up, I have tried to offer a full and transparent account of my reasoning : I have stated what my participant said, how I am interpreting it and why. Whilst quotations must be valued, their status remains open to question, however. In my research, I have used quotations largely as illustrative examples, that enhance and enrich description, rather than as 'evidence' (in a positivist sense).

**Communicative validation** - "Communicative validity involves testing the validity of knowledge claims in a dialogue" (Kvale, 1996, p.244). Here, different communities can be brought in to validate a researcher's interpretations : the participants themselves; the scientific community of scholars who possess both methodological and theoretical competence in the research area; and the general public who interpret the research within a critical commonsense understanding analogous to that of a jury.



In my own research, I have used all three communities to test out my findings :

- i. I engaged in participant validation throughout my discussions with the participants, as I checked out meanings and tested my understandings of what they seemed to be saying during their interviews. Validation also occurred in a more formal way when two participants read and commented on the written analysis I produced on the basis of my interviews/observations with each of them. However, whilst it was reassuring at one level to gain my participants' assent, I also recognise its provisional status. Rather than using my participants to confirm my findings, I opened my findings up to my participants out of interest and to gain additional data about their point of view. This compromise position avoids buying into any notion of one 'truth' or one where the participant's view is privileged.<sup>2</sup>
  
- ii. My supervisors monitored and guided me through the research process, ensuring my research was methodologically trustworthy. They had access to all the interview transcripts and to my observation notes, enabling us to engage in a full discussion about each participant. Through these discussions, I tested out my interpretations and, in turn, my supervisors provided comments which enriched my analysis. However, it is important to acknowledge that my findings would have not been invalidated had my supervisors disagreed with my understandings. Any difference in findings could simply be a function of their particular perspectives. Further, they only had access to texts (transcripts) as data, whereas I had additional experience to draw on, having participated in a research relationships.

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<sup>2</sup> In his critical exploration of participant validation, Ashworth (1993) supports it on moral-political grounds but warns against taking participants' evaluations too seriously as it may be in their interest to protect their 'socially presented selves' : "Participant validation is flawed nevertheless, since the "atmosphere of safety" that would allow the individual to lower his or her defences, cease "presentation", and act in open candour (if this is possible), is hardly likely to be achieved in the research encounter" (Ashworth 1993, p.15).



iii. Through published articles and conference presentations, I have laid my findings open to a wider public : the occupational therapy community. In no sense have I expected a full endorsement of my conclusions, but had this community not generally accepted my findings about the experience of being an occupational therapist, the status of my research would probably have been severely compromised. Instead, the response from occupational therapists has been generally positive and evidence from conference discussions suggests that they have already begun to build on my research. As Kvale (1996) argues, citing the work of Mishler (1990), "valid knowledge claims are established in a discourse through which the results of a study come to be viewed as sufficiently trustworthy for other investigators to rely upon in their own work" (1996, p. 245).

## **Summary**

This section has mapped the many philosophical and methodological choices I have made in the course of my research. I have justified my selection of an interpretivist, constructivist paradigm and shown how my research is underpinned by assumptions arising from three theoretical approaches : social constructionism, phenomenology and hermeneutics. I have explained how such approaches carry significant implications in terms of research method employed, ethics and the different processes involved in analysis and evaluation. In the next section I turn to method, giving a detailed account of my participants and the research procedures adopted.



### 3.3 RESEARCH DESIGN AND METHOD

The aim of my research has been to describe the life worlds of occupational therapists from the point of view of the research participants. Qualitative methodology, in the form of in-depth unstructured interviews and participant observation, was employed in order to access the therapists' meanings. A phenomenological approach was adopted where what individuals expressed was assumed to reflect their perceptions of their life world. Further, I attempted to bracket my presuppositions in order to genuinely and actively attend to the participants' views. Phenomenological thematic analysis was undertaken to capture the therapists' own sense of their reality.

This sub-section on research design and method details information on my participants and the data collection and analysis procedures adopted.

#### **Participants**

##### The sample

Twelve occupational therapists participated in this research : Nine occupational therapists were interviewed; three therapists were shadowed in participant observations (one of whom I had also interviewed); and then I include myself as a participant as I employed reflections and reflexive observation. All the therapists were experienced in that they had practised for at least two years and had trained within the last 10 years (i.e. they had been on the modern diploma/degree course programmes). They worked in a range of (adult) health care contexts, namely physical and psychiatric hospitals, social services and community mental health. Two of the hospital therapists



worked in specialist units (neurology and forensic psychiatry), whilst the others maintained a wider, generalist role. The therapists all carried a clinical load and some of them carried additional management responsibilities. Table 3.3 provides a summary account of the participants' names, level of experience, and the health care setting and also how they were involved in this research project.

None of the therapists were known to me personally. But as they all worked within my region (convenience sample), I had some familiarity with their particular health care settings. This helped in the choice of units to sample.

NAME (pseudonyms)	LEVEL OF EXPERIENCE	HEALTH CARE SETTING	RESEARCH INVOLVEMENT
MARY	1	community mental health	interview
SUSAN	2	community mental health	interview
CATHY	1	community mental health	interview
PAULA	2	community physical (social services)	interview
JANE	3	community physical (social services)	interview and participant observation
STEPHEN	2	physical hospital	interview
KAREN	2	physical hospital (specialism)	interview
JULIE	3	psychiatric hospital	interview
JENNY	3	psychiatric hospital (specialism)	interview
PETER	1	physical hospital	participant observation
ANNE	3	physical hospital	participant observation
MYSELF	3	not currently applicable	researcher

Key :    1 = limited experience;    2 = fairly experienced;    3 = very experienced

Table 3.3 Summary of participants and their work experience and setting



### Descriptions of the participants

A brief description of each of the participants is offered below. In lieu of biographical details I have tried to acknowledge their individuality and capture the ‘feel’ of their individual responses to work.

**Mary** - Mary has worked as a community mental health occupational therapist for just over a year and is just now beginning to gain an understanding of her role. She sees herself primarily as a ‘counsellor’ offering supportive and educational counselling. She struggles to be a ‘proper’ therapist - one who is valued and respected by others. She remains confused about her role and lacks confidence as a counsellor (though feels she has some specialist occupational therapy knowledge). She believes she has an important and meaningful contribution to make, and that keeps her going at work when she feels pressured. Mary has just been seconded on to a part-time college course which she enjoys as it gives her ‘time out’ and the possibility of developing specialist expertise.

**Susan** - Susan is an experienced community mental health therapist. She is deeply committed to using a client-centred philosophy in her practice and feels that to be effective it is essential to listen to the client’s voice and expressed needs. She values occupational therapy because she sees it as more client-centred and holistic than other health professions. However, she has struggled over several years of practice to find and define an occupational therapy identity. She now feels confident and comfortable in her role, despite experiencing conflicts and feeling frustrated by her more medical, diagnosis-orientated colleagues.



**Cathy** - Cathy is a community mental health therapist. She feels insecure and unsettled in her job, partly because she is new and therefore uncertain about her role in the team, and partly because she feels she could be made redundant at any time. She lacks confidence in herself as a professional and questions her role and identity. She believes others do not value occupational therapy and she feels unable to promote a role for herself. She is tempted to adopt a counselling role (which she sees as more valued) but she is conscious of her relative lack of training in this area. Away from role concerns she enjoys her daily contact with clients and finds the work both rewarding and satisfying.

**Paula** - Paula works as an occupational therapist in social services - an identity about which she feels relatively strong, confident and valued. She is clear her role is primarily that of a practical problem solver who is guided by certain criteria, procedures and financial constraints. She loves her work and enjoys being a 'professional'. She cares about her clients but experiences intense pressures of time given the volume of referrals she has to process. However, she also sees a positive to this in that she is forced to prioritise more and limit her involvement with clients, which helps her cope better. Paula is currently working part-time having previously worked full-time.

**Jane** - Jane works as an occupational therapist in social services. She is an experienced therapist having worked previously in both mental health and social services elsewhere. She sees herself as both a practical problem solver and a "mega-rescuer". She cares deeply about her clients, almost considering them her friends or the 'children' she doesn't have. She feels valued by her clients and confident that her quiet, gentle approach is effective at a one-to-one level. However, she also has the



task of constantly balancing their requirements with the realities of financial constraints. Jane enjoys the independence and autonomy her work affords as she travels around the county in her car visiting client's homes.

**Stephen** - Stephen works as an occupational therapist in a physical hospital covering mainly orthopaedic wards. He has struggled since qualifying to find his role, balancing intense pressures of referrals with the ideals of holistic practice he gained from college. After practising for a couple of years he now feels more confident, comfortable and effective. Stephen experiences much of his work as if patients are on an assembly line as he is required to assess large numbers of patients and process them for discharge. He accepts this role as part of the reality of working within a medical hierarchy. Although he is clear that this role is valued by senior managers, he feels more satisfaction when he can get more deeply involved in longer-term rehabilitation.

**Karen** - Karen works in a physical hospital unit which specialises in neurology and rehabilitation. She enjoys working as a specialist and strives to become even more knowledgeable and expert. She works closely with the physiotherapists and seeks to learn from them, viewing them as more expert than occupational therapists in movement therapy. In this way she has turned slightly away from her occupational therapy role while continuing to enjoy her specific occupational therapy contributions. As a senior therapist she feels she has less time for patients than does her occupational therapy assistant, but she still enjoys the contacts she has with them (which are related primarily to retraining in personal care skills and movement patterns).

**Julie** - Julie is an occupational therapist who works in a large psychiatric hospital. As an experienced, senior therapist who has practised for a number of years, she carries



both a clinical and a management role. She loves both her patients and working as a therapist, and passionately believes in what she has to offer. Over the years she has struggled to promote occupational therapy, sometimes unsuccessfully, to other team members. She has also invested much effort in managing change and moving the service towards using purposeful (as opposed to diversional) occupational activities geared to individuals' needs.

**Jenny** - Jenny works as an occupational therapist in a specialist forensic psychiatric hospital secure unit. As an experienced therapist, she has both a clinical and management role. She is stimulated (both positively and negatively) by her contact with patients, feeling fascinated and repelled by their acute pathology and mental disturbance. She values her occupational therapy role and feels very comfortable carrying out a range of practical rehabilitation activities. Over the years she has worked to encourage inter-disciplinary teamworking where there is a mutual respect for different professionals skills. She is both challenged and stressed by her newer, more demanding, senior management responsibilities.

**Peter** - Peter works as an occupational therapist on the orthopaedic wards in a large, busy physical hospital. He is relatively inexperienced and a little unsure about his practice, but is slowly gaining confidence. He has worked to develop interview schedules and check-lists to guide his interventions, and feels good about this. The quick turnover of patients creates much pressure on time and minimises how involved he can become with patients. He believes in his role of facilitating discharge and enabling independence in the personal activities of daily living. He is enjoying his work as a therapist and is keen to develop his skills and gain experience.



**Anne** - Anne works as an occupational therapist on the surgical wards in a large, busy physical hospital. Although she is an experienced therapist (having worked for many years in the field of learning difficulties), she has limited experience of surgical practice, so she is still exploring her role. However, her experience enables her to feel confident and easy handling patients and gaining positive responses from them. Anne currently prefers the safer boundaries of working practically in a physical setting, not least because she is able to limit her emotional involvements. She utilises her therapist (i.e. 'facilitator') skills in her work as a manager, which she also finds satisfying though challenging.

**Myself** - My occupational therapy background is in the mental health (hospital setting). However, I currently work as an academic with the Open University teaching Social Science and Social Psychology. I am also involved with some course writing and production. I retain some involvement with the occupational therapy world through participating in conferences, writing occupational therapy textbooks and serving on the editorial board of the British Journal of Occupational Therapy.

#### Access to settings and participants

I obtained my sample of participants through my contacts at a university which ran an occupational therapy degree course. My colleagues knew the names of practising therapists in a range of different health care settings in my region. I asked my colleagues to suggest the names of therapists working in specific contexts (e.g. community mental health) who would be "good to interview".



On being given names, I randomly selected one person, whom I contacted by telephone. Adopting an informal approach, I explained the nature of my research and my desire to interview therapists about their experience of working within the profession. Often the names I received were those of head therapists. Where this was the case I gained their agreement in principle that I might interview one of their staff. We then negotiated which of their staff best fit my criteria (that : i. they should have qualified within the last ten years; ii. they should have at least two years clinical experience; iii. they should not be known to me personally). The managers would then approach their different staff members and ask if anyone was interested to take part. If a therapist came forward, he or she contacted me by telephone, or I was given their name in order for me to contact them.

In line with my informal approach, all the participants gave their verbal consent to be interviewed/observed verbally and, where relevant, this consent was sanctioned by their managers. Assured the data would be confidential and that they would remain anonymous (e.g. pseudonyms used), the participants consented to have the interviews audio-taped. On my part I agreed that we could turn off the tape at any point and that the participants would have access to their transcripts and my findings if they wished. In the case of the participant observations I was required to negotiate permission to observe with the managers, and this needed to be in writing.



## Data Collection Procedures

### The Interviews

Each of the nine interviews lasted approximately one and a half hours; the therapists themselves decided when they had said enough and had given enough of their time.

Each interview was audio-taped, then transcribed verbatim, and each participant received a copy. Care was taken throughout each interview to be sensitive and responsive to the participants and to facilitate their ability to express themselves.

**Setting the scene** - The participants themselves chose when and where to have the interview. Interestingly, all but Paula and Jane selected the clinic during work hours. They also controlled arrangements relating to privacy (for instance, whether or not they told colleagues what I was doing). On first meeting the therapists I was usually offered a cup of coffee (which I accepted) and then we would move to the interview room. I let the participants organise our seating arrangements, only taking care to have a central table on which to place the small tape recorder.

I began each interview by reminding the therapist what we had agreed over the telephone and by re-stating the aims of the research. The form of words I used varied but it was something along the lines of: "I am interested in your experience of work as an occupational therapist - your view of your role, your clients. I am less interested in the rhetoric of what 'OT' is. Instead I would like to understand what it is like to be you as a therapist."



**Interview procedure** - I sought to maintain an informal, friendly style and a relatively non-directive approach, having minimally structured participants' focus by asking them to describe their work experience. For the most part, I asked open descriptive questions concerning, for instance, their 'typical day'. Occasionally I would ask more specific interest questions like "who is your favourite patient?" I employed a range of techniques to facilitate the participant's expressions, for instance, reflecting back and summarising. I also tried to regularly check out their use of terms (especially professional ones) in an effort to avoid making undue assumptions about what they meant. In each interview I would apologise in advance for 'asking obvious questions'.

Throughout the interview, I was conscious of using myself to help build a rapport with the participants. To a degree I was engaged in an exercise of impression management. Primarily I wanted to appear both 'professional' and an 'insider' in an effort to encourage their trust and enable them to feel safe with me. To this end I dressed in a casual but smart mode. I tried to be relaxed, friendly, spontaneous and reasonably informal to encourage similar 'open' behaviour in my participants. I emphasised my status as an insider by openly empathising with their typical occupational therapy dilemmas and by using humour, such as laughing with them at their 'in' jokes. I also endeavoured to use their own terminology (e.g. 'patient versus 'client') to demonstrate we were on the same wavelength. In order to facilitate their willingness to talk frankly, I occasionally shared personal material about myself.

As each interview was drawing to a close I would attempt to recap what I had heard as the main points expressed. I invited the participant to make any corrections and other comments, asking them, "Is there anything else you feel you would like to say - perhaps that you have missed out?" I then invited questions about the research, what I



was going to do with the material, and tried to be as frank and honest as possible in my responses. I promised to send each participant a transcript and invited them to come back to me at that point if they had further comments.

**Reflective diary** - I maintained a reflective diary throughout my data collection. This included : field notes; a record of my subjective reactions; and analytic notes.

- a) *Field notes* - My field notes comprised straightforward factual details about negotiating access and describing the circumstances of the interviews (for instance, the time, place, behaviour of participants and how our relationship evolved).
- b) *Subjective notes* - The field notes were supplemented by notes on my subjective responses where I recorded my personal attitudes and emotional responses towards both my participants and the data collection/analysis procedures.
- c) *Analytic notes* - The analytic notes were periodically written - for example, after the first four interviews. Here, I sketched research strategy, noted emergent ideas and generally evaluated my progress.

In combination, these notes provided the baseline for my subsequent reflexive analysis (see section 4.3). Whilst the diary has essentially remained my own private record, my supervisors read most of the notes and we thoroughly discussed its content.

### Participant observation

I shadowed and observed three occupational therapists over the course of their working week. For one week I observed a therapist working in social services (Jane). I then observed Peter and Anne (separately over two different weeks) as they went about their work in their particular physical hospitals. Detailed notes were taken,



including both 'observations' and 'reflections'. These were developed into a preliminary analysis of the therapist's life world and reflexive analysis respectively. All the therapists received a copy of my observation notes (minus my personal reflections). Only Jane received a copy of the preliminary analysis as an exercise in participant validation.

**Negotiating access** - I started the participant observations by gaining official permission to observe the therapists concerned. In the first observation both manager and therapist were clear about my research agenda, whereas in the other two observations I simply had permission to observe and allowed the managers/therapists concerned access to my observation notes.

My public role as far as all the managers and therapists were concerned was to act as an 'observation student'. This ensured that access to all areas was relatively easy as the system was accustomed to accommodating student observers. Also, my professional qualification acted like a passport; I was accepted as a professional who could be trusted to behave appropriately and keep information confidential. Without this qualification, a police check and letter from my research supervisors would have been required. As it was, I was accepted with minimal questions.

Once inside the field, my professional qualification also eased my passage. I was, by definition, a stranger, an outsider. Yet in a subtle way I was accepted as an insider by the occupational therapists concerned and their occupational therapy colleagues (who knew me or knew of me). I, too, felt on familiar ground, despite never having worked in either social services or physical hospitals. The health care issues, the jargon, the practical problems, the home visits, the 'caring' staff interactions and tensions within



the wider team, were all familiar to me. Despite this commonality of experience, I was also in alien territory. The focus on diagnosis, physical problems and bits of equipment was all unfamiliar.

This combination of familiarity and strangeness proved useful for the research. My ease with the organisational set up helped me to be comfortable in my interactions, which in turn aided people's responses to me. My appearance, behaviour and such factors as my age, sex, race and class were deemed 'appropriate' and helped me to blend in. I was also able to be accepting of any less-than-perfect practice, for example, by saying "I know how it is", which seemed to minimise the therapists' defensiveness. The unfamiliar attitudes and procedures helped me identify the questions to ask. I could more easily question assumptions.

On the other hand, my qualified status meant I was a threat. This proved particularly the case with Peter, who was clearly very self-conscious about his performance and was aware of my academic and writing background. Being more experienced, Jane and Anne seemed to treat me as an 'equal' more easily and I remain unsure if they even knew of my background.

The final stage of my access was to negotiate my 'cover stories', i.e. how my presence would be explained to wider staff and patients/clients. The participants and I agreed that I would simply be an 'observer'. The wider team members were likely to assume I was a student occupational therapist (particularly when I wore that uniform) and we decided we would let them believe this unless questioned directly. Being a 'legitimate' observer allowed me to take notes and ask questions relatively freely.



**The participant observer role** - I adopted different sorts of observer roles (Junker 1960) depending on the context. When in the presence of patients/clients (for example, on the wards or in their homes), I tended to adopt a 'complete observer' role where I was not expected to participate actively. Sometimes the patients/clients would include me non-verbally through their eye contact, and although I would respond warmly when required, I tried to remain unobtrusive (for instance, placing my chair a little to one side).

With staff, I was accepted as a 'participating student/colleague'. This role allowed me to ask questions, write notes and check out impressions generally. In formal meetings I did not wish to interfere with their normal working so I remained quiet. I believe the non-occupational therapy staff accepted me as a ('complete participant') student - a perception which afforded me legitimacy and a right to be there but limited perceptions of my status : I was judged to be not worth talking to.

**Data collection** - My means of data collection included unstructured observation, reflection and note writing. In an effort to appear relatively unobtrusive when the therapists worked with patients/clients, I took my lead from the therapists. For example, while observing Jane, I made it a point when we visited clients' homes never to accept a coffee until she did first. I only wrote notes when she did; I spoke only when asked a direct question; I would wait for her to choose her seat and sit down with the client before I sat. With all these behaviours I aimed to have minimum impact on Jane, her work and her clients, I wanted to emphasise her relationship with the clients and maintain my marginal observer status.



Being relatively unobtrusive allowed me plenty of space to sit back, observe and reflect. My observations were unstructured in that I was alert to picking up a range of verbal and non-verbal behaviours. However, I was particularly interested to observe any personal reactions and relationship dynamics between the therapist and his or her patients/clients.

Once back in the office (or in the privacy of Jane's car), I would 'interview' (informally) the therapists about their clinical reasoning and responses. In this way I was able to compare my observations and reflections with theirs.

As all three therapists had to write notes themselves fairly frequently, I had plenty of opportunity to write and reflect throughout the day. On returning home after each day, I made notes and expanded them. I then audio-taped my observations and reflections, including my personal responses and some analysis, transcribing the tape in my own time. This daily exercise was time consuming, absorbing around two hours a day, but it enabled me to capture considerable depth of data.

By the end of each week of participant observation I had data on a hour by hour description of what we had done and the therapist's behaviour. I also had data on :

- the therapist's relationship with, and responses to, the patients/clients
- the therapist's reactions and expressed attitudes
- my own reactions and attitudes
- my thoughts on what it was like to be that therapist
- my reactions to participant observation and evaluation of the method.



### Preliminary analysis

My preliminary analysis took place in stages :

- 1) I started by attempting to separate out my **observations and personal reflections**.
- 2) I then worked on a **reflexive analysis**, drawing heavily on my reflections. I paid particular attention to : i. the influence of my professional background and identity (including my assumptions and issues surrounding my insider status); ii. the dynamics of the relationship between myself and my participants (for instance exploring how Peter and I exchanged novice-expert roles); iii. my emotional reactions (for example, whether I had felt interested, distressed and ambivalent); and iv. evaluating the use of participant observation as a method.
- 3) I then attempted a more 'objective' thematic analysis of the occupational therapists' life worlds. I first focused on their experience of **being an occupational therapist**. As an illustration, when analysing the hospital therapists I considered : i. their view of their role; ii. when/where/how occupational therapy took place; iii. their personal concerns and ambivalent responses; iv. their experience of working relationships; v. their pressures and coping strategies.
- 4) Then I focused on my participants' **view of patients/clients** and how that impacted on their therapist-patient relationships. Here certain themes emerged, among them the ambivalent situation of power battles co-existing with respect, liking and caring. I also noted the therapists' use of social/moral categories and how they pragmatically labelled patients/clients according to diagnosis and functioning.



## Data Analysis

The aim of the phenomenological analysis was to capture the world from the participant's point of view. The data was analysed in three stages. First, I carried out an *analysis on each individual* participant. Then I looked across all the individual accounts and produced a *generic analysis*. This was later refined into a more succinct *global analysis*. Throughout these stages I aimed to be systematic, yet also spontaneous and intuitive. I aimed to be involved, immersed and empathetic, yet also distanced. I was involved in the task of analysing, yet I tried not to be too analytical and to let categories emerge.

### Individual analysis

In the first stage of analysis, my focus was on each occupational therapist as an individual. I aimed to understand and capture his or her experience, to avoid assuming that what I heard might link up with the experience of the other occupational therapists. I started by immersing myself in the transcript, repeatedly listening to the participant's descriptions. I combed through the transcript and broke it down into a sequence of numbered meaning units (i.e. phrases which seemed to express a distinct content). The process of going through the text line by line, which generated approximately 1,800 meaning units per interview, helped me to attend and really 'dwell' on what was being said.

I then pulled out key sections and lingered on the clusters of meaning units which seemed to express particularly meaningful, significant points. I tried to probe what



was being said and how it was said, taking note of relevant non-verbal communication such as pauses and emphasis. I also attended to what was not said. As far as possible I aimed to set aside my presuppositions to avoid distorting what the occupational therapist had intended.

I then identified key categories, concerns and issues and allocated these to different topic headings : for example, 'view of self'; 'relationship with others'; 'view of work'. My categories were developed and expanded using the meaning unit quotations as illustrations. Themes and sub-themes emerged as points were clustered together and re-labelled. Throughout this analysis, I continually returned to the transcript as a whole, re-reading it to maintain a gestalt, a 'feel' for the person.

Over the course of several days, I reflected further on my analysis, trying to pick up points of incompleteness, ambiguity, contradiction or conflict and see relationships between sub-themes. As I focused intensely on small descriptions of feelings, it was almost as if I were exaggerating the experience in order to capture it. Using the technique of imaginative variation I tried to determine essential characteristics related to the participant's existential experience. Sometimes it helped to interrogate my analysis using questions like :

- What does it mean to be this person? Who does he/she think he/she is?
- What are his/her goals and what does he/she think about?
- Is he/she constantly aware of something, i.e. is there a script which keeps playing?
- Why does he/she feel a need to...?
- Where does he/she experience his/her day? Are some places safer than others?
- How does he/she experience his/her day? Is it pressured, slow, discontinuous etc?
- How does he/she feel about relating to others?



The final stage of the individual analysis involved writing an in-depth summary of : the key themes; sub-themes (with illustrative quotes); and a more reflective account (based on my field notes and diary) of my own responses/interpretations. Throughout this process I worked hard to try to describe the person's life world rather than offer my interpretation or explanations.

### Generic analysis

Once the individual analyses had been completed, I was ready to focus on the links between the therapists. I compared and contrasted all the analyses, looking for commonalities and variations.

These themes were then explored and developed in turn. I started by writing notes on each theme related to each individual and I dwelt on relevant quotes from across the interviews. Sub-themes emerged. For instance, the theme of 'facilitating change' seemed to involve many different dimensions, including the need to feel valued; the thrill of transformation; the therapist as a hero; collaborating on change; being challenged and succeeding where others have failed; being creative; and feeling effective/ineffective.

I paid particular attention to ambivalences, ambiguities and points of individual variation, as participants' meanings often varied. For instance, 'caring' was a sub-theme which emerged under the therapist-patient relationship theme. All the occupational therapists wanted to be caring, but this was interpreted in different ways



at different times by each of them. Sometimes it meant being intensely involved; at other times it meant maintaining an efficient, professional distance.

What emerged at the end of this stage was a generic analysis based on nine themes which seemed to connect the therapists' stories : i. Searching for an identity; ii. Striving towards holism; iii. Facilitating change; iv. Good patients/bad patients; v. The therapist/patient relationship; vi. Support and conflict in the team: the battle to be valued; vii. Experiences in the health care context; viii. Coping with the emotional assault; ix. Enacting the occupational therapy craft.

### Global analysis

On completing the generic thematic analysis, it became apparent that some of the themes clustered together naturally. For instance, searching for an identity and striving towards holism seemed to overlap to an extent, while facilitating change seemed tied up with the therapists' sense of their craft. The generic analysis was therefore subsequently restructured and distilled into four global themes, namely :

- Who am I? The fraught search for an OT identity
- The mission to make a difference : enacting the therapist's craft
- Negotiating the boundaries : the caring-power relationship
- Safe haven or battleground? Collaboration and conflict within the team.

These four global themes, which are explored in depth in section 4, seemed to capture something of the common experience of all twelve occupational therapists.



### **3.4 REFLECTIONS ON THE JOURNEY TOWARDS A METHODOLOGY**

#### **Starting the Journey with Preconceptions**

I started my research journey feeling reasonably clear about ‘research method’ and what I was going to do (namely, a qualitative, ethnographic study). I had wanted to pursue and extend a research project that I had carried out in my undergraduate degree on constructs/typifications of an occupational therapist. So I carefully defined my parameters; my academic experience had taught me how important it was not to flounder aimlessly at the beginning.

I could see my path. But I was also prepared to deviate and explore other trails. In fact I knew this was necessary to ensure my journey contained sufficient challenge and new experience. So when my supervisor, Peter Ashworth, suggested I might like to take the phenomenological route I agreed. I did not realise this decision would so fundamentally and irreversibly transform my research direction and understandings.

My first hurdle came early in my passage into phenomenology. I had thought I would adjust easily to the concepts and methods, given my familiarity with the experiential - humanistic literature and practice in occupational therapy. However, as I started to read the work of Husserl and Gadamer and others, I found myself in completely new territory. Moreover, I did not understand what I was reading - something which, while prompting anxiety, was also stimulating and challenging.



More disturbing was the feedback I received after my first interview. I was told that I was not in tune with a phenomenological approach. I was being too directive, presupposing too much, not being sufficiently empathetic and not focusing sufficiently on concrete descriptions. It shook me somewhat. Given my experience as a therapist, I had felt reasonably confident and comfortable about my interviewing skill and capacity to be empathetic. Now I knew I had some work to do. I needed to learn what was so different about phenomenology. And what were my supervisors actually saying about post-modern, post-structuralist positions on reality?...

For orientation, I turned to the literature (specifically Denzin and Lincoln's 'Handbook of Qualitative Research') and found myself in awe of this new world. I had always been committed to qualitative research methods but I had had no idea that the underlying methodologies were so rich, sophisticated and complex. It was an exciting, if somewhat daunting, discovery. It began to dawn on me that I had major methodological choices to make.

### **New learning, new questions**

I began to see how the qualitative research paradigm contained many contradictory strands. Approaches diverged in their notion of reality as well as their aims and methods of research. I now understood that 'post-positivists' believed reality could be glimpsed whereas 'constructivists' *only* accepted social constructions. The materialist base of more 'critical approaches' asserted a reality in contrast to the fragmented, relativist, multi-voiced representations of the 'post-structuralists'. Post-positivists



supported a plurality of research methods aiming to develop theories; constructivists aimed to describe; critical theorists sought to emancipate. Post-positivists and critical theorists pursued objective analysis, whilst constructivists and post-structuralists preferred subjective, reflexive analysis.

I remained wary of treading too far into the territory of the relativism located in the more extreme post-modern, post-structuralist interpretative works. The nihilism inherent in their assertion that there was no reality was scary. With some relief I latched onto a post-positivist position - it seemed so comfortable, familiar and easy to grasp. But then I would do some more reading and be persuaded to support another view. I was confused but also actively questioning, as illustrated by this extract from my reflective diary :

*Will I ever be able to come to a conclusion on which is the 'best' qualitative approach? Do I - does my research need a clear commitment? At the moment I am reconciled to being easily swayed. I seem to attach myself to whatever I am reading at the moment! When reading Hammersley, I find his arguments persuasive and I reaffirm a post-positivist stance. Then I read Guba and Lincoln and know that I am a constructivist! Then I have to acknowledge I want to embrace more critical goals, for instance to use my research to uncover how power operates to undermine both patients and professional autonomy. How can I be so inconsistent!?*

Immersed in this exploration, I discovered that I was experiencing some tensions about relinquishing positivism in favour of more naturalist/interpretivist approaches - a not surprising development in view of the fact that positivism remains the dominant methodology for both OT and psychology. For one thing, I struggled with my tendency to 'seek the truth'. I questioned if my informants were telling me the truth and if interviewing them again, or gaining more of their trust, would somehow allow me to 'really get at' their reality. I gradually understood that if I did this, my



informants would only talk in another voice - it would not necessarily be more truthful, just a product of a different personal-social moment.

At a more specific level, I reluctantly let go of Kelly's personal construct theory (a long-time favourite of mine), now recognising its cognitivist, positivist bias. I had started to question the view that it is our thoughts which shape behaviour and that it is possible to measure these constructs scientifically. A person's knowledge, intentions and acts were clearly more than a cognitive process originating in the mind; rather, they arose within a social world and involved multiple meanings and intersubjective understandings. In practice this meant I needed to study the therapists' wider experience of how they negotiate their world, not simply focus on their way of classifying patients.

I also experienced tensions about embracing phenomenology. My leanings towards social constructionist and sociological approaches contrasted with the individualistic, descriptive focus of phenomenology. How could my belief in structural explanations of society be incorporated into the essential liberalism of phenomenology? Whilst as a therapist I was comfortable with humanistic approaches, as an academic, my understanding had become much more social and political. My research was leading me down a path of relatively uncritical description rather than analysis - was this going to make it a 'weaker' study? Would I be able to resolve the tensions? Whilst I now see it is possible to mesh sociological and phenomenological analyses (as, for instance, in social constructionism or in the works of Goffman, Merleau-Ponty and others), initially, I could see only the contradictions. By way of compromise, I increasingly separated my research method (phenomenological) from my beliefs (about which I was discovering I was not at all clear!).



Thus, my conversion to phenomenology, or rather to embracing it as a method, was effected. I turned away from the literature (a deliberate strategy, aimed at helping me bracket my theoretical understandings) and focused on my data collection and analysis.

As I gained experience of carrying out phenomenologically orientated participant observation and interviewing, I began to grasp the phenomenological theory better. For instance, I found the participant observation particularly helpful in helping me to see the world from another's view point, as opposed to analytically understanding what someone might be going through. I was able to reconnect with past feelings and experiences related to my struggles to be an effective occupational therapist. This in turn helped me to 'understand' better, to be more sensitive and less critical.

It was with some relief that I found my understanding of phenomenology increased as I progressed through each interview. Initially I struggled with what I was 'supposed' to capture. My supervisors kept dropping pointers, suggesting I 'try to be concrete, capture actual moments of experience' or that I 'do more with lifeworldly aspects of temporality, spatiality'. I struggled to understand what these concepts meant. I also experimented (through a process of trial and error) with how to handle the analysis. I tried initially to work with 'meaning units' but eventually left these behind in favour of 'dwelling' on more 'whole' excerpts or quotations.

Throughout the uncertainty of this learning period I drew comfort from the security offered by my subjective analyses and reflections - perhaps I knew I couldn't get this 'wrong'!. I held firmly to the significance of being reflexive. From the beginning of my research I had kept a diary of my reflections. I also engaged in reflexive analysis. I



knew this would be important to my research, I just wasn't quite sure about its final form and status.

## **Accepting phenomenology**

It wasn't until my seventh interview, and the analysis which followed it, that I began to feel comfortable with my method. When I returned to re-analyse some of the earlier interviews I realised just how far I had developed. Also my commitment to phenomenology as a methodology had rather crept up on me. It had grown, alongside my emerging understanding of the method in practice.

I recognised that my personal bias towards social constructionism as a perspective was continuing to tinge my analysis in that I still felt drawn towards social psychological explanations. But I realised that my commitment to using a phenomenological method, regardless of personal leanings, was also reasonably strong. For instance, I valued the significance of the 'life-world', extending the description to mean the individual's meanings and habits as he/she relates within social groups and cultural context. I was content to move away from dichotomies between nomothetic and idiographic approaches and to relinquish clear-cut conceptions of studying 'reality'. Instead, I could embrace the study of individuals' meanings and consciousness, followed by a search for possible general themes. I found I valued the idea of 'reduction' and the attempt to see a phenomenon freshly from different angles. More importantly, I could believe in the phenomenological process as being sufficient in itself, not just an initial preparatory exploration. I certainly did not feel any need to 'confirm' my findings by



adopting positivist methods, inserting quantitative data or applying multivariate analysis 'just in case'. I was content to reject any attempt to quantify my material - and that included using any of the so-called phenomenological, ethnographic software programs.

I was also comfortable with, and even began to enjoy, the ambiguity, ambivalence and untidy outcome of phenomenological analysis. Instead of feeling dissatisfied with producing partial, tentative pictures, I began to believe this was the best that anyone could hope to do. Paradoxically, accepting the emergent, ever-shifting nature of my data and analysis offered a strange security. Perhaps I was being liberated somehow from having to produce a 'right' or definitive answer.

### **Becoming immersed in phenomenology**

Although I had begun to feel comfortable with phenomenology I was also confused. I felt I had been able to grasp something of what was meant by the 'life world' and had captured some lovely phenomenological moments when analysing (such as how I sensed Jane was 'in love with her car' or how Jenny felt threatened sexually), but I was also uncertain about how 'phenomenological' I was being. My grasp of theory was weak, in particular I found it difficult to appreciate the differences between Husserl and Heidegger. There were also contradictions in elements of my method. Whilst I tried to 'dwell', stay with my participants' views and voices, I was uncomfortably aware of making many interpretations. I was also unclear about what seemed to be the contradiction between 'bracketing' and exploiting reflexive insights.



I knew I would have to return to the literature to clarify these points. It was appropriate that this should be in the latter stages of my generic analysis. Opening once again, the pages of Quentin Skinner and other books, I resolved that ‘this time I would understand’...

What an exciting time this proved to be - both stimulating and rewarding. So much suddenly (finally!) slotted into place. I saw these ‘texts’ in a completely new light and they began to make sense. I was able to articulate (and to some extent evaluate) the work of theorists like Husserl and Heidegger. I saw that the differences between these philosophers were truly profound. I realised Husserl’s commitment to the ideas of transcendental phenomenology and epoche stood in contradiction to Heidegger’s more existential-ontological-hermeneutic analysis. More clearly than ever before I was able to see that I could not accept Husserl’s positivist ideals - his objectivism and aim of eidetic study to identify general essences. Moreover, I could not agree with his focus on consciousness alone and his assumption that it is possible to achieve a pure, ‘transcendental ego’ - to bracket out presuppositions. Instead I favoured Gadamer’s ideas of the ‘fusion of horizons’ of subject-object. As a researcher, I did not believe that I could adopt a position outside of my socially constructed reality from which to assess some objective reality. Instead, I was beginning to favour Merleau-Ponty’s position of modifying the concept of bracketing to mean setting aside research/theory presuppositions in order to reveal engaged, lived experience.

Heidegger’s focus on being and experience, with its greater attention to meanings and interpretations made more sense to me. Moreover, Heidegger’s hermeneutic circle seemed to better fit what I had been trying to achieve with my reflexive analysis.



While I remain both bemused by his unending circular abstractions and disturbed by his anti-humanism and political history, I have no difficulty in accepting his notion that we engage in a continual dialectic between pre-understandings, interpretations and what is being revealed. I also resonate positively with Heidegger's focus on Being and engagement in practical everyday activities - clearly a familiar occupational therapy theme (although I recognise on this point that his anti-rationalist position takes his notion of Being and authenticity in a different direction from what they mean to me as an occupational therapist). Most of all I liked his insistence on the historical-cultural situatedness of human 'reality'.

My next revelation came from reading van den Berg's "A Different Existence". It was only after immersing myself in the powerful way he described a life world that I felt I had really begun to understand the concept. I also began to grasp the notion of 'pre-reflection' and became aware that much of my previous understandings about 'subjective reflection' in fact contradicted the phenomenological approach. I could see how introspection/reflection (about something) was potentially problematic and distancing. By separating subject from object, the sense of pre-reflective 'being' can get lost.

## **Current understanding**

Today, I believe I have at least some grasp of phenomenology, however patchy and inadequate. For one thing I'm uncomfortably aware of my over-reliance on secondary sources. Also, I feel as though I have only started to read the phenomenology



literature. But if I have much to do to develop my understanding of 'phenomenological philosophy', I do at least have a sound grasp of 'scientific phenomenology'. It is comforting to remind myself that my research is not in the realm of philosophy; I am essentially pursuing phenomenology as a tool, not as the end itself.

On the positive side, I feel comfortable overall with phenomenological methodology. I am comfortable with its key ideas and I take much pleasure now in reading phenomenological articles. I get the most pleasure from realising that I follow the arguments - for instance, Crotty's (1996) critique of the nursing research which in turn received a wonderfully scathing critique from Giorgi (1998) when he reviewed his book!

Moreover, I have come to understand better some of the links between phenomenology and occupational therapy. In particular, I can see links between existentialists' notions of doing/being and occupational therapy concepts of active participation, engagement and doing. The notion of intentionality has a real flavour of therapists' ideas of engaging in activity. Further, the way occupational therapists treat the concept of 'occupation' as activity in combination with meaning is essentially phenomenological in spirit. I can also see how occupational therapists are fundamentally concerned with enabling patients/clients to re-enter, or engage with, a new life world.

As a result of my project, I have come to value phenomenology, specifically its potential for research. Although it is not an easy research option, it does have the



potential to capture meanings and experiences - I think better than any other method.

I will certainly return to this methodology in future research.

I have learned much, and continue to learn. It is satisfying to be able to see the way my learning and development has evolved. I had not appreciated when I started research the extent that I would have to rethink and reposition myself. I had underestimated the number of new ideas and techniques I would be taking on board. I have taken a different road from the one originally intended, even if the direction has remained unchanged.



## 4. ANALYSIS

### 4.1 INTRODUCTION

Phenomenological understanding is distinctly existential, emotive, enactive, embodied, situational, and nontheoretic; a powerful phenomenological text thrives on a certain irrevocable tension between what is unique and what is shared, between particular and transcendent meaning, and between the reflective and the prereflective spheres of the lifeworld.  
(Van Manen 1997 p.345)

In my attempt to capture some of these tensions and to reflect them in my analysis of the therapist's life world, I offer four distinct ways of presenting my research findings :

- **Section 4.2 The experience of being an occupational therapist :** In this sub-section, I offer an analysis of the four global themes identified which capture something of the therapist's life world.
- **Section 4.3 Reflexive analysis -** This more personal analysis examines the impact of myself as researcher on the research process and findings.
- **Section 4.4 The life world of the occupational therapist -** This brief account of the life world offers a summary of my findings overall.
- **Section 4.5 Reflections -** I provide a personal account of the analysis process.



## 4.2 THE EXPERIENCE OF BEING AN OCCUPATIONAL THERAPIST

Four global themes seem to capture the experiences and meanings of the occupational therapists interviewed and observed in this research :

- Theme 1 : Who am I? The fraught search for an occupational therapy identity
- Theme 2 : The mission to make a difference : Enacting the therapist's craft
- Theme 3 : Negotiating the boundaries : The caring-power relationship
- Theme 4 : Safe haven or battleground? Collaboration and conflict within the team

Each theme, and emerging sub-themes, will be explored in turn, then brought to life using exemplars and the therapists' own voices in the form of quotations. A summary of the sub-themes without exemplars and quotations is laid out in section 4.2.5.



### 4.2.1 (Theme 1) :

## **WHO AM I? THE FRAUGHT SEARCH FOR AN OCCUPATIONAL THERAPY IDENTITY**

It is important to all the therapists to define and articulate their role. They all recognise the difficulties inherent in this task as there are no clear guidelines. They come into their jobs feeling confused about what occupational therapy is and its core theory. What it means varies for each of them. They feel a need to construct professional boundaries relevant to their particular work context. However, this process is fraught with difficulty as they are confronted with mixed messages from others (colleagues, patients, college lecturers) about what they can and should be.

All the therapists are similar in that they subscribe to a holistic, person-centred philosophy where they attempt to value and respect their patients/clients as individuals with unique personal and social histories. But while they strive for holism in theory, the practical realities of the work context mean they also operate within more reductionist modes - a contradiction they all have to negotiate. One particular concern for them is how to balance working with their socially orientated, client-centred models within the medical model used by doctors, nurses and other professionals. Their inconsistent and ambivalent use of medical diagnoses testifies to this.

In different ways they are all enthusiastic about occupational therapy and embrace its values. At the same time, they move away from it and take on other professional identities/roles. They face a common struggle to construct a clearer identity for themselves in a changing world. How they express this and how they cope with their ambiguous position differs between individuals.



In this context four key sub-themes have emerged :

- a) **Valuing and rejecting the occupational therapy** : We're enthusiastic about occupational therapy but we want a different identity.
- b) **Struggling to define boundaries** : The conflicting meanings of occupational therapy are confusing.
- c) **Compromising on holism** : Patients should be viewed as 'people', but the practical realities of the work context make it difficult to avoid categories and labels.
- d) **Constructing a new identity in a changing world** : We feel the need to demarcate a territory and stake a claim for a new, more prestigious identity.

**Theme 1 : a) Valuing and rejecting the occupational therapy :**

**We're enthusiastic about occupational therapy but we want a different identity.**

- i. Occupational therapy (OT) is valued, and believed in, but it is not enough.

**Julie**, remains enthusiastic about occupational therapy. She loves and values it, embraces the philosophy. At the same time, she feels occupational therapy is not enough - she feels a need to specialise further. So she has pursued the additional qualification of dramatherapist. Dramatherapy excites her and she feels it enriches her occupational therapy practice. She is thus ambivalent about occupational therapy - she loves it but is also bored by it and feels she is not a good advertisement for it :

I ought to make more opportunities to talk to people about what I do, because that tends to remind me about how much I love what I'm doing. That's why I like having students here. Because, one of the consistent comments I get from students is that I'm enthusiastic, passionate about what I do. I think 'great, that's what they need to see'; but that's what I need to feel as well.

I'm actually a bad advertisement for OT, because if somebody asks me to do a domestic skills assessment my heart sinks. I know that really they're necessary and important and need to be done well, I just don't get excited about doing them.

[Dramatherapy is] something that I've wanted to do for a long time. It's something I have achieved for myself, and of course that's changed the way that I work as an occupational therapist. It's broadened it.

(Interview 8, p.18, 6, 10)



**Peter and Anne** are ambivalent about their work as acute physical occupational therapists :

- a) They appreciate being needed to 'facilitate discharge' but feel occupational therapy has a potentially more valuable role extending into the community (as evidenced in discussion and by their commitment to work hard on home visits).
- b) They value the treatment focus on practical, personal activities of daily living and the concept of 'independence'. They know they have a critical role in assessing safety factors (on behalf of the patients and in terms of litigation anxieties). On the other hand, they get bored by the routine nature of this work. These contradictory values were implicitly revealed by the therapists' selective focus on personal activities and their assumption that patients valued this, whilst at the same time off-loading as much dressing practice as possible on to the helpers. As Peter said, "So many times you are not satisfied."
- c) They enjoy the variety and fast pace of their work though sense their limited focus is superficial and less meaningful.
- d) They both try to avoid receiving too many referrals (as the helper commented, "They keep their heads down.") - yet they also enjoy these pressures as referrals confirm they are valued/appreciated professionally. (Participant Observation 2,3)

ii. Having a diminished sense of being an occupational therapist results in embracing other roles. Occupational therapy is the passport to be other things.

**Mary** sees herself as primarily doing counselling and she has no particular sense of having an occupational therapy identity. She believes occupational therapists can be anything - they are adaptable and bend to different tasks. She does not feel she really understands the occupational therapy role (she has never worked in a hospital where roles are less blurred) and feels vague when describing it. She values some of the qualities she picked up from her training which she associates with occupational therapy. These include being adaptable, holistic and non-judgemental. For Mary occupational therapy becomes a passport to do and be anything :

I'm willing to see anybody, anywhere sorta thing. And that maybe does come from the training - the adaptability?...I either say I'm an occupational therapist or that I work in a team. I guess a lot of people don't know what an occupational therapist is, so sometimes I'll say it and sometimes I won't. If I think they are going to have an understanding of the difference, then I would say – explain vaguely the difference.  
(Interview 1, p.21-22)

**Karen** sees herself as primarily a member of a multi-disciplinary rehabilitation team where roles overlap. Her sense of identity as an occupational therapist has diminished since she moved towards a physiotherapy role by specialising in "movement patterns". She enjoys being an occupational therapist, however, as she sees it as an easier job than being a physiotherapist. As an occupational therapist she feels she is able to relate



to the patients more, less knowledge and skill are required and she does not have as much “hassle” :

We tend to work very closely with the physios, so a lot of it appears to be physio biased – so what we did was actually physio kind of stuff before we could start on the pure OT if you like.

You’re usually at the side so you can see what they are doing there as well as what their body is doing, rather than just purely at the back—so it’s much easier to relate with a patient than if you’re a – it might be harder for a physio. (Interview 7, pp.1, 14)

## **Theme 1 : b) Struggling to define boundaries : The conflicting meanings of occupational therapy are confusing.**

### **i. Searching for an identity to become a ‘proper occupational therapist’**

**Susan** was so confused about the occupational therapy role (particularly in community mental health) that she carried out research on this and discovered she was not alone. She tussles with her need to search for a role and identity whilst at the same time she feels it detracts from the fundamentals of relating to her clients. She struggles with questions about the occupational therapy role boundaries (e.g. whether counselling is legitimate occupational therapy) but then feels her own personal skills/experience might be more relevant anyway :

This whole thing about role is a difficult and ongoing thing for OTs. It feels like we’re always having to look at our role, we’re always having to look at what we do... we put so much energy into looking at what our role is, that we actually negate some of the real fundamentals about- you know, is it about what we think we should be doing? Or is it about the basics about acknowledging the person and acknowledging their needs, really seeing them and really listening to them?...If I stick with the starting point is the person and then look at how their difficulty...relates to the skills, experience and knowledge that I have got, then that is what is important. Rather than saying that as an OT I should be doing activity analysis and not getting into dilemmas about ‘is counselling really OT?’ (Interview 2, p.11)

**Susan** has struggled with her sense that she is not a ‘proper’ occupational therapist. She has put herself under stress searching for an answer only to discover that it’s up to her to set out her values - to grasp that if she is sufficiently client-centred then she is doing “proper OT” :



For a long time I had this image that I was going to find this thing that told me what an OT was, and what I should do, you know, and I think you know, what I did was put myself under a tremendous amount of stress and pressure, and thought I'm not working as a proper OT, and that somewhere, behind this big rock, was this oracle that would tell me what is a proper OT." (Interviewer : What is a proper OT?) "To me, I am working as an OT if I am working with clients and I am working in a meaningful way and actually looking at, with them, their difficulties.  
(Interview 2, p.11)

**Cathy** is finding her feet in a new job and is trying to forge an occupational therapy identity based on core skills, though she remains confused about what these may be. Yet before she is even clear, she feels forced to justify her role to other professionals. Justifying her existence is harder to do as she has no real specialist skills/experience :

It feels difficult having to justify yet again your existence... [Occupational therapists] feel very angry about that... I think that when you specialise in a particular area you are bound to develop extra skill, additional skills and certainly I know one or two other OTs who have done extra counselling courses and things. You can, in effect probably move away from you core skills, so what I did was I went through a period of I suppose thinking, 'well, what am I doing? Am I doing an OTs job here or not?' Which was quite a big thing to think about, particularly, I suppose, being a new OT in the community, I am still finding my feet, I'm still in my own mind clarifying my role and where I am and how I fit in.  
(Interview 3, p.2)

## ii. Past versus Present - shifting images of occupational therapy

**Jenny** defines her role in terms of therapy tasks undertaken and in this way she is clear about what occupational therapists do. But she is also not clear. She distinguishes between occupational therapy in the past and what is offered in the present. Traditional occupational therapy involves activities and groupwork. These treatments are still undertaken but currently the role is changing / evolving with more role blurring and less certainties :

We now have groups up and running that the nursing staff I know have wanted to do for a long time, and have felt very tied and very obstructed in what they wanted to do. It was always seen as OT territory.

I'm very clear about what we do do. Yes we do a bit of groupwork; and we do a bit of counselling; we do do a bit of activity. Maybe we're not that clear!  
(Interview 9, pp.5, 6)

**Stephen** has struggled to discover the occupational therapy role. He sees himself as having come through some tough learning. He feels he was confused about his role in the past and even came out of college being uncertain. Now, as a more experienced therapist, he sees himself more clearly as 'facilitating discharge' :



It was very difficult, in the first year or two I was qualified... Yeah, I mean I came out of college not really sure of what the OT role was, um—I think it just took time.

(Interview 6, pp.8-10)

**Julie** battles against traditional images of occupational therapy - the 'basket weaving' images involving diversional activities without individualised aims or a clear sense of underlying theory/philosophy. She looks back at that type of occupational therapy with horror. As a manager she has struggled to turn the service round. But such change has taken many years. She has had to battle with old-time staff and has fought against the enduring images of occupational therapy as it was :

When I first came here it was awful. OT had the most horrific reputation... There was no treatment programme... And it took us a long time to lose that reputation – it probably took ... three or four years. When I came down here as a Senior II, I reckoned I'd turn the place round in six months. And I'm still trying, eleven years on.

(Interview 8, p.2)

**Theme 1 : c) Compromising on holism : Patients should be viewed as 'people', but the practical realities of the work context make it difficult to avoid categories and labels.**

i. Patients/clients need to be seen as individuals with their unique needs and particular personal/social histories.

**Susan** aims to start treatment by trying to understand her clients' values and views of their problem :

The starting point is the person. The starting point is their actual make-up, their actual belief systems, their whole perception of what is the problem, and that everything must start from there.

(Interview 2, p.5)

**Mary** sees her clients as individuals whose mental health problems are a product of their own social history and current relationship dynamics. She is also aware of



professional philosophy and is careful to use the right terminology, correcting herself if she thinks she has lost sight of the person's individuality :

She's in her late thirties. Very chequered history... Her husband's an alcoholic and was referred to see a colleague, and she asked for somebody to go and see her. Basically she was abused as a child, but she is also in a co-dependent relationship. And it's a very sort of chequered history. But what I find with her is that she actually tries to make changes. We started looking at issues about their past; then it went through a phase about her and her husband because he was binge drinking at the time and she could not concentrate on herself so that's why we decided to do that; and now that that's sort of settled down we can look back at her. I suppose at the beginning she was like a typical abuse...its not typical abuse.  
(Interview 1, p.7)

**Paula** sees her clients as individuals who have problems which can affect their whole life. She finds she can sometimes identify with her clients - particularly young, newly married women :

There was a young woman with... and I think, I really did identify with this person, she had the um.. got this.. repetitive strain syndrome. She'd worked as a secretary and done a lot of work on computers, constantly over a long period of time...she had it very severely, to the state where she couldn't work, they sacked her from work, she could do very little in the house, ...I mean, making a drink was a real strain for her. Um, but she was a young woman, newly married, and I really, I mean I could do very little for her.  
(Interview 4, p.14-15)

**Susan** and a number of the other occupational therapists feel so strongly about being holistic and person-centred they refuse to use the words 'patients' or 'clients'; emphasising that they are in fact 'people'. Somehow the words 'patient' and 'client' are seen as derogatory - a pernicious label - and must be avoided lest the work of these therapists is contaminated by dehumanising, institutionalising concepts :

We don't use the term patient anymore. And to me its more about how I actually deal and interact with a person who is in need of the service. The client is a person, rather than a client.  
(Interview 2, p.1)

## ii. Being 'holistic' means different things.

**Susan** sees her task is to be 'person-centred' and to start from the clients' individual needs. She aims to develop a relationship and really listen to what the person is saying. She considers that she needs to do this in order to be a safe effective practitioner. She also resists labelling and classifying clients into boxes :

If I really listen to the person, then I can really explore with them, putting together an effective treatment programme. If I don't listen and I think about



the diagnosis or what I should be doing, or what skills I have got, I'm not effective because I'm bringing my own side of things into that.

(Interview 2, p.14)

**Julie** also rejects labels and tries to be accepting of any negative behaviour and history. She also strongly encourages her patients to make active choices. She sees her practice as having a strong existential foundation :

Highlighting the possibility of actively making choices rather than letting life happen to you, which is something I push quite a lot with virtually every client I deal with. So it would be fair to say that my work also has a strong existential flavour.

(Interview 8, p.13) [see also theme 4 sub-section a) iii.]

**Paula** tries to respect her clients' choices and wishes, even when she strongly disagrees with their decisions. However, she still feels the need to try to persuade her clients to accept her advice initially.

She was absolutely adamant that she did not want a stairlift. So I said, "I have to respect that. It's your home". Because it's their home, and it's their life, and it's their situation, you have to respect that. I said, "I can only advise you strongly, and I will need to put down in my notes how I felt about the situation.

(Interview 4, p.11)

**Jane** tries to respond to what she sees the client values, needs or wishes. Sometimes this means doing things she dislikes. For instance, despite "hating" one client's dog. She goes out of her way to shower it with attention, because the dog was especially dear to this client. On another occasion she suffers some handholding from a male client as she feels he "needs the extra touch and attention".

(Participant Observation 1)

**Karen** views her patients in terms of their bodies and physical movement patterns but sees the body as a whole system and avoids focusing on isolated parts. She also tries to see how that person used to be prior to their admission (before their trauma) :

I don't even notice if a patient puts on a dress or anything because I'm looking to see where their shoulder blades are." But she then goes on to 'correct' herself, "...it is easy to think of patients in terms of their posture, but not just a shoulder blade, its more the whole thing put together, because if you've got a bad foot, then its going to send the hips out and its going to send everything out.

(Interview 7, p.13) [see also theme 2 sub-section e) i.]



**Cathy** believes occupational therapists are holistic because they learn about physical health, mental health and learning disabilities. As an occupational therapist she considers herself holistic. As part of this she tries to see her clients in the context of their family and she also aims to help them to have a fulfilling life :

The things I feel are important are, well its all the jargon - its looking at them as the whole person really. Primarily, that I have training in three areas, physical, learning disabilities and in mental health. So I can look at that person as a whole and see them in the context of their family as well, for starters. But I want them to, or to be able to, encourage them to, um, have a fulfilling life.  
(Interview 3, p.3 )

iii. Tensions are experienced between occupational therapy values and the demands of the system.

**Stephen** feels angry and frustrated at the way the management, financial constraints and an excessive work load force him to compromise and to practise at a superficial level looking at basic ('bog standard') issues related to discharge planning. He prefers longer term rehabilitation as it gives him the opportunity to get to know his patients as people. The management does not value this aspect and he feels he has to toe the line or face the possibility of losing his job.

[see theme 4 sub-section d) i. and iii.]

**Susan** feels frustrated at how the Community Service Team she works within is not client-centred. She feels a tension between her values as an occupational therapist (which she locates in terms of her professional training) and the way the Service forces people into boxes. She experiences conflicts within the team as she believes many of her colleagues are not as person-centred as she is :

Now to me, as an OT, one of the things that I have always held onto very strongly is that you fit around the person, not that you fit the person to the service. I find that one of the biggest things to actually work within, because it doesn't feel to me at the moment , the way things are going, that the Services accommodate people. It feels that people are expected to accommodate the Services, and I find that really hard. I suppose that's more to do with some of the philosophies that I was educated with as an OT student rather than the actual skills I've got. Its more about the beliefs, and I think that's one of the things that I see very differently to some of my colleagues who come from a different discipline. I'm not saying that they don't see the whole person, but it seems that the whole belief about really looking at people is something that as OTs, or as an OT, I feel I've got a much better grasp of than some of the people that I work with.

(Interview 2, p.4-5)

**Peter** and **Anne** both grapple continually with the tensions generated by having to focus in a more reductionist way on personal care functioning while treating patients more holistically and recognising their individuality. The way the system is organised with the occupational therapist required to confirm the patient is safe to be discharged,



creates much pressure on them to assess patients quickly obliging them to adopt a production line approach. Peter and Anne both value independence in self-care, and they choose to maintain this reductionist focus (marginalising hobbies, work relationships etc.). Peter checked out how one patient managed cooking and dressing but not her hobbies or married life. Anne undertook supplying a wheelchair for another patient in an efficient business-like manner and did not delve into other possible problems.

The focus on personal independence activities does not preclude recognising other factors, however. Anne, for example, seemed very attuned to picking up personal motivations - a key component of her skill in communicating with patients. Within one minute of meeting one particular patient, she picked up that the individual was house-proud and did not want to drop her standards. Both therapists seemed to view patients more holistically when it was relevant for effective treatment. Anne sought information about her patients' occupations as part of ensuring safe, caring discharges. Peter went out of his way to work with relatives to facilitate smooth, supportive discharges.

Thus, the more the occupational therapists engage in treatment as opposed to just assessment, the more the patient becomes a person. However, work pressure means it is impossible, and probably unnecessary, to engage more fully with every patient. (Participant Observation 2,3)

iv. Medical diagnosis should be resisted so as not to stereotype patients/clients.

**Julie** actively resists using diagnosis as she feels any psychiatric label devalues the person. She feels diagnosis is often not very helpful as it does not tell her about the person's needs. However, she also recognises that a diagnosis can be useful as it may help her understand what someone is experiencing. But overall she stays away from diagnosis, feeling that this is the doctors' or other team members' province :

I see her as a person in her own right. I guess that's how we see most people around here. Having a psychiatric label does little for your value as a person... I don't find them particularly useful... We don't go a bundle on psychiatric labels in the department as a whole. Occasionally it is useful to know... about the processes about what may be going on for somebody and what they may be experiencing... to be aware that somebody may be experiencing auditory hallucinations and what affect that might have on them... you could have two people with totally different psychiatric diagnosis who you would be working on exactly the same aims of treatment with... again it is useful to know what side effects, what problems people may be experiencing with the medication, but if people want advice on medication and stuff like that, then I will point them in the direction of somebody who knows what they are talking about, like a doctor or pharmacist.

(Interview 8, p.14)

**Cathy** has mixed feelings about using psychiatric diagnoses. On the whole she avoids them as they are too general and she prefers to view her clients in terms of their problems and life. She feels that a person's diagnosis shouldn't really matter.



Sometimes, however, she takes the team's diagnosis on board and makes associated assumptions. She also freely (and unselfconsciously) uses diagnosis to categorise less favoured clients. Thus she labels clients she does not see (namely, 'psychotics', 'drug addicts' and 'personality disorders') :

I don't take psychotics, but having said that I have been working with somebody for the last year who it does turn out has a psychotic illness... I mean whatever their diagnosis is doesn't bother me, but I suppose it's natural, in that we're all human beings, that you are drawn to some people more than others. And there are certain issues, or certain types of behaviour that I find harder to deal with than others... but it doesn't stop me... working with them.  
(Interview 3, pp.15-20)

**Paula** uses diagnosis as a basic descriptor but tries to also recognise the individuality of each person's condition. She acknowledges that the diagnosis offered on the referral forms does not really give a proper picture. She sees herself as a 'professional' who is able to look beyond diagnosis and see deeper implications. However, she also uses diagnosis to get an idea of prognosis and the person's likely long term needs :

They put those down on the form and you're not really getting - cos a stroke, the severity of a stroke could vary from someone having weakness in one side of the body to literally not being able to move... it's the details that mean so much to a fellow professional.

There's a young gentleman at the moment with, um, M.S. and he's only young. He's married with a young family... there's absolutely no way of knowing because it's such an individual condition, is M.S. Following the general trend, that gentleman is going to deteriorate.  
(Interview 4, pp.3, 17)

**Jane** works within a system based on a medical model and the use of diagnosis (it is the routine way of classifying clients on referral and in meetings). However, she tries to focus on the person and his or her functional ability. Diagnosis is only a small part of the picture and only makes sense in the context of how the person handles the condition :

She is a lady who has fought very hard against her disability. She is a very determined lady and her disability is quite severe. She has very restricted heart function, she's got very arthritic hips and knees. She's actually due a hip replacement, but she's only in her early 60's. She's very young looking in her outlook and has a lot of young people coming to the house.  
(Interview 5, p.5)

**Stephen, Karen, Peter and Anne** contrast with the mental health and community occupational therapists in that diagnosis and the medical model play a central part in their roles as physical hospital occupational therapists. The patient's diagnosis is the starting point of their clinical reasoning and it triggers a pre-set treatment formula. Further, diagnosis is most relevant in terms of safety/precautions (a pressing concern



for all of them). Despite their reliance on diagnosis, however, all these therapists also try to see their patients in individual terms.  
(Interview 6,7; Participant Observation 2,3)

v. Contradictory use of labels? Categorising within a holistic approach.

Whilst the therapists go some way to resist medical diagnoses, they all routinely classify and categorise their patients/clients. They also engage in their own professional diagnoses, for instance, when formulating a person's problems. Most of the categories applied are relatively benign, organisational devices. Occasionally, the categories sit uncomfortably alongside holistic practice.

Three types of categories emerge : a) categories concerned with patients' functioning; b) social categories; and c) categories related to treatment needs (i.e. types of patient groups). Although the therapists share some categories, the latter mean something different to each individual.

- a) *Categories concerned with patients' functioning* - All the therapists demonstrate a commonality of purpose in their focus on patients'/clients' functional skills and problems : their ability to carry out their daily work, leisure and self-care activities. Patients/clients are routinely categorised into how independent they are, or how well they can concentrate or manage their anxiety. Therapists' specific focus and emphasis varies according to their setting/priorities. The physical occupational therapists tend to concentrate more on self care and physical coping, whilst the mental health therapists are more concerned with leisure and degrees of emotional coping.
- b) *Social categories* - Less predictable are the use of categories which define people's identity in terms of social factors such as class, gender and age (race and ethnicity was absent from all their discourses). Social factors are seen as important by all the therapists as they use them routinely to describe patients/clients, for instance saying "middle aged woman" or "single man in his 30's" etc. Thus patients/clients are seen as people - people who could be stereotyped to a degree. Overall, the therapists differ in what they see is important. For instance, on the subject of class :

**Stephen** sheepishly admits to preferring his 'easier', more nicely behaved middle class patients as opposed to the patients from a neighbouring inner city who had more social problems. Significantly such evaluations seem to occur in the context of trying to obtain positive treatment outcomes rather than simply passing moral judgements :

At the risk of sounding a snob, yes you know, it's a nicer client group to work with... It's easier sometimes if there's something specific that the people need, a large piece of equipment, quite often the family can afford to buy it if it's not available through Social Services.

(Interview 6, p.7)

**Peter**, in contrast, prefers his working class patients - particularly the older ones from South Leeds, as they remind him of his grandmother and heritage (Participant



Observation 2). **Mary** feels critical of a colleague who unduly emphasises social class; she believes class should not matter and should not make a difference. She feels she should see anyone without making such judgements :

I've got clients in every walk of life almost. Up to now we haven't had what you might call 'down and outs' or I haven't had very affluent... We tend to get people somewhere in between... I don't think it makes a difference... I'm willing to see anybody, anywhere sort thing... The thing about social class - There is a colleague here, that when he describes a client, he will say - if it's somebody who is a bit more affluent, he'll kind of mention the house and surroundings as well as the client. I find that quite amazing! Because that's obviously important to him. Whereas to me, I wouldn't think of mentioning it. (Interview 1, p.21)

Gender is a particular issue for **Julie** and **Jenny** - both of whom have been sexually/emotionally threatened by some male patients/clients. Their awareness of potential sexual threat sometimes makes them feel vulnerable and insecure.

- c) *Categories related to treatment needs* - The therapists all employ different categories relevant to their work situation. The crucial point is the meanings the categories hold for the individuals concerned. Two examples of this are how Jane separates out 'social need cases' from 'genuine clients' and how Mary distinguishes between 'mental health' and 'mental illness'.  
[see theme 3 sub-section f)]

**Jane** distinguishes between the real, "genuine need" cases where there is a clear-cut physical handicap and the "social need" cases where poverty is the over-riding problem. These two groups are also differentiated on referrals as the social need clients require an application for central heating and not a therapeutic intervention. These categories are somewhat ambiguous, however, and confuse Jane. For a start, the idea that there are 'genuine' clients suggests implicitly that the other clients are 'not genuine'. But Jane is unhappy with this suggestion (and she contradicted me when I tried out the term). Similarly, the 'social need' label signals someone who does not have a physical handicap - yet some of Jane's social need clients are badly handicapped by their asthma, so are 'genuine' too. At a more socio-political level, Jane is uncomfortable in her views as to whether or not these clients have the right to 'exploit' the welfare system.  
(Participant Observation 1)

**Mary** sees herself as treating shorter term 'mental health problem clients' who have potential to change, as opposed to 'mental illness' clients who have chronic problems. Mary believes there is only a limited amount that can be done for the mental illness clients besides managing their condition with medication. She is relieved not to have to treat these "long-termers" as she feels they are less responsive ("flat"), so less satisfying to deal with. In contrast, Mary sees her mental health clients as having more reactive problems (i.e. stress related to relationships, unemployment etc.). She distinguishes between people suffering from anxiety, those with depression and those



with personality disorders. She believes clients with these problems tend to have temporary or transient “bad times”, but that they can usually be helped out of these with input like anxiety management, supportive counselling, assertion training and so on :

I would say at the moment I’ve got more what I would call mental health clients, rather than mental illness clients... I would distinguish a mental illness client, as someone who has got, like, a chronic schizophrenic or manic depressive illness. Rather than somebody who is going through more of a reactive, short term... short term may be months to a few years, but not a lifetime.

I guess I haven’t had that many ‘long-termers’... by the time you get people who have been on medication for a long time it takes the edge off the personality ... and you don’t get that motivation.  
(Interview 1, pp.2, 19)

## **Theme 1 : d) Constructing a new identity in a changing world :**

**We feel the need to demarcate a territory and stake a claim for a new, more prestigious identity.**

### **i. Carving out specialist territory in search for more status.**

**Karen** has sought to emulate physios as “people are used to deferring to physios” (Interview 7, p.8). She is hungry to learn their specialist neurology, gain their movement skills/knowledge and so gain some of their status. As she says, “...to be an OT in neurology, you need to be a physio first.” (Interview 7 p. 2) She has joined their in-service programme to learn from them and develop her craft.

In a similar way, some of the other therapists have also shifted into different professions **Julie** qualified as a dramatherapist. **Jenny** and **Anne** have been increasingly drawn into being a manager first and occupational therapy second. They have all felt enriched by these moves and have gained confidence.

The same cannot be said of the community mental health occupational therapists. : **Mary, Susan** and **Cathy** have all embraced counselling as their primary role. Their use of counselling feels somewhat illegitimate and raises questions for them as to whether or not it is an occupational therapy role. More pertinently they haven’t been specifically trained as counsellors so feel inexperienced, to the detriment of their sense of confidence. However, counselling also feels prestigious to them and it does offer a clear-cut role :



Mary : I suppose the bulk of our work is more what I would call supportive counselling... Its more of a kind of superficial level almost... I would say there are a small number of my caseload...really need more what I would call intensive therapy. I think the nature of the clients that we tend to get through are more - superficial - you know they're going through a bad time... I think the very intense clients, because I haven't had that many of them, those are the ones that I would need more supervision with... Then there are the intense ones who do progress, and those are the ones where I think, 'yeah, we've got somewhere here'... it takes much more effort...you feel as if you're actually doing something. Whereas the ones that come and go, a lot of it seems like common sense, and you think, 'well anybody could have done that'.  
(Interview 1, p.15)

## ii. Split identity : evolving multiple selves

Whilst the therapists all want to be holistic and person-centred in their approach, the realities of work pressure impose competing demands. The therapists respond to this challenge in different ways. Commonly, they split themselves into different professionals - sometimes acting in a person-centred way while at others acting in more 'efficient', reductionist modes. In this way they evolve multiple professional selves.

The therapists move in and out of these different professional selves, responding to patients/clients in different associated ways. Mostly this is achieved with some ease; difficulties are experienced when they would prefer to act in a different way. Sometimes the two selves are experienced simultaneously and, as they contradict each other, it can feel uncomfortable. Mostly the two different approaches are viewed pragmatically as a trade-off between experiencing satisfaction through treating more people and treating fewer people in greater depth.

**Susan** experiences her clients in two different ways : first, she is a person-centred therapist and experiences her clients as a 'person with needs'; second, she is a service professional and sees her clients as 'service users'. When she experiences them as persons she sees them as having difficulties and needing her help. But with her service hat on, she is more reductionist and focuses on certain problems - namely the problems that are prescribed. She also limits her contact time with these clients (down to half an hour as opposed to over an hour). Susan perceives the service (and therefore at times herself) as dismissive of clients who do not fit the standard criteria of 'acceptable' problems.

Sometimes she can bring these two professional identities together and it feels good - cognitive dissonance and tensions are reduced. At other times her selves are in conflict. The service self restricts interventions and provides a minimum service. The person-centred therapist is moved to try to help in any way and is upset by the service's dismissive, uncaring response :

Susan : The client is a person, rather than a client. They are a person who's got a need, who needs something from the service. And I think that if I'm part of the service, and I've got something to offer, then I can call that person a client, or I can call that problem something else.



Interviewer : It's interesting. When you look at a client, or a person, do you almost see them in two different ways then?

Susan : Yes... I see them as a person and I see them in terms of the wider framework : me as a part of the service and them as a user of the service. So I have these two things going on at the same time... sometimes I can work that really well. I'm human and sometimes I don't work it that well, because it's two different things, it's a different set of priorities.  
(Interview 2, p.3)

**Stephen** has evolved two separate identities - one to satisfy the managers, the other to satisfy his professional self.

Stephen is under pressure to treat more patients quickly to enable quicker discharges. Often the treatment he offers here is a "rubber stamping exercise" to conform to legal requirements. He views his patients as if they were on a fast moving conveyor belt and he sees around 25 patients a week. As they all require similar interventions (for example, dressing practice) he finds the work boring and routine. [see theme 4 sub-sections d) i. and iv.]

Such work contradicts his occupational therapy values of striving to be person-centred and offer meaningful treatments. In order to satisfy both the managers and his needs, he splits himself into two modes - in effect, two therapists. One self is a 'procedural technician' who works efficiently, mechanically employs set routines and does not get involved. His other self is the 'person-centred therapist' who is a committed, involved therapist who likes to work with individuals in a deep, meaningful, long-term way. As he describes it, "It's just being aware of the person as opposed to the patient, creating a person out of it."

(Interview 6, p.10)

### iii. A new occupational therapy? - Re-defining the boundaries

**Julie** has struggled to reshape the occupational therapy service in line with changing perspectives on needs of psychiatric patients. Her battle has been to develop a new service with individualised treatment aims. She feels she plays a key role in motivating staff and developing their skills towards the new vision of occupational therapy :

We need to deepen our theoretical awareness of what we are doing. Um, the way I put it to people the other week was, I was doing an inspirational speech...[the occupational therapists] are missing out on the key parts of the process there. Yes, we will get people to meet aims and objectives, but they don't always realise that, which is a real loss. And if we could spend more time focusing at the beginning of the session.

(Interview 8, pp.17-18)

**Mary** and **Cathy** both struggle to carve out their territory within the context of the role blurring which is practised in community mental health teams. They have both



been drawn towards similar areas : counselling, being the specialist in groupwork, and doing anxiety management (i.e. not seeing psychotic clients who need medication) :

Mary : I think its nice because although we all do similar sort of work, each profession has its own sort of speciality if you like. Like the nurses, if I didn't know anything about medication, or somebody needed an injection, I would go to a nurse.

Interviewer : How are you different?

Mary : ... there are certain aspects like equipment, or someone's got a physical condition, or groupwork type things. We all run all the groups and just sort of change over. But it still tends to be the OTs who are the group orientated people.

(Interview 1, p.23)

Cathy : There are certain things that are across the board for most professions. I suppose treating people as a whole and this sort of thing is pretty common, and I guess, you know I would argue again that we have, or are particularly trained in groupwork, and that's why I am doing groups in the community - you know, sort of stress management type groups. (Interview 3, p.3)

## **SUMMARY of theme 1**

The therapists all experience an ambivalent relationship with their profession. On the one hand they are proud of, and value, occupational therapy. On the other hand, to avoid the struggle to define boundaries, they adopt other roles and professions as well as defensive practices. They are engaged in a common search to define and construct their own occupational therapy identity. Each battles to forge an identity whilst negotiating the contradictory definitions and demands around, though the precise way they handle that struggle and how well they cope varies between individuals and different contexts. Each therapist manoeuvres to hold on to holistic values in the face of the realities of reductionist practice.



#### 4.2.2 (Theme 2) :

### **THE MISSION TO MAKE A DIFFERENCE : ENACTING THE THERAPIST'S CRAFT**

In spite of their ambivalence about their role, the therapists share a love for what they do. They believe in occupational therapy and feel it is meaningful. They take pleasure in their craft - it is what they *do* that gives them satisfaction. They have a mission to help others, to make a difference.

The theme of 'change' figures prominently in all the therapists' stories. To bring about change is their main aim of treatment; patients'/clients' treatment outcomes (regaining capabilities, being discharged, returning to the community or being empowered to try something new) are deeply important to them. Change is their reason for working.

The process of change is rarely experienced as easy. Instead, changes are seen to occur over time and to involve much challenge and struggle - for both therapist and patient/client. The greater the challenge, the bigger the thrill of the transformation.

The biggest thrill of all is experienced when the occupational therapist is able to bring about change where others have 'failed'.

When the therapists succeed in making a difference, they feel satisfied. When they are unable to make a difference (i.e. where there is no progress or the patient/client ignores their advice) work is experienced as dissatisfying and frustrating. The therapists then internalise messages that they have failed - that they are inadequate or insufficiently skilled in some way. Their sense of achievement, effectiveness and competence comes from feeling they have enabled change. They can feel effective when they are valued and appreciated.



Each therapist engages in a complex process of treatment planning where they consciously and strategically use themselves as treatment tools towards enabling change. This is their craft, combining both art and science. They engage in both an intuitive and logical problem-solving process which entails constructing a narrative of patients'/clients' functioning in the past and present and their potential needs for the future. The therapists then exercise their craft further in their creative use of therapeutic activity - a satisfying process involving mutual participation.

Six key sub-themes within the broader theme of having a mission to make a difference have emerged :

- a) **Believing in the mission** : Occupational therapy has an important value and purpose.
- b) **Enabling change - the struggle and thrill of transformation** : The therapy process is a challenge, but it feels worthwhile when positive changes take place.
- c) **Striving to feel effective, valued and appreciated** : Changes observed in patients/clients are associated with feeling competent and effective. When patients/clients are stuck, it's frustrating and we question our skills.
- d) **Strategic planning or intuitive magic?** : The approach in therapy is carefully planned but sometimes solutions come intuitively and spontaneously.
- e) **Practical problem solving - envisioning the past, present, future** : Focusing on tactics to overcome functional problems.
- f) **Being and doing through activity** : Striving to capture the creative moment and enjoy the mutual participation.

**Theme 2 : a) Believing in the mission : Occupational therapy has an important value and purpose.**

i. Occupational therapy is a worthwhile and meaningful occupation.

**Karen** sees the change take place in patients and knows her work is both worthwhile and exciting :



It's always exciting when someone is improving... sometimes the ones that you look back on that you like the most are the ones that have been the biggest challenge to you. And you think, 'Well, I didn't think we were going to get there in the beginning, but we did it!'. (Interview 7, p.14)

All the **physical occupational therapists** believe in the value and purpose of enabling independence and working on self care. Their work has a meaning. They feel they are contributing something important to their patients/clients. They are making a difference. [see theme 1 sub-section a) i.]

ii. The work evokes passionate commitment, but sometimes motivation slips.

**Julie** is passionate about her work and what she can offer her patients. She feels she needs this level of enthusiasm to carry on. She also has to remind herself of this occasionally when her motivation goes :

I love what I'm doing. That's why I like having students here. Because one of the consistent comments I get from students is that I'm enthusiastic, passionate about what I do. I think, 'Great, that's what they need to see.' But that's what I need to feel as well.  
(Interview 8, p.18)

**Theme 2 : b) Enabling change - the struggle and thrill of transformation : The therapy process is a challenge, but it feels worthwhile when positive changes take place.**

i. Seeing progression take place over the course of treatment is fascinating, exciting and rewarding.

**Julie** gets particularly excited when she sees significant changes in how her patients relate to others. She shares in their growth and triumph :

Julie : Where I get really excited is at change... Change in how people see themselves and see themselves in relationship to the world. That's, for me, the significant sort of change.

Interviewer : Can you give me some examples (?)



Julie : ...A woman who's been through a 22 week group for adult survivors of sexual abuse, and we had our last session yesterday. I came out of the group room..., possibly looking a bit tired, and she came out and just said 'Oh, come here, give me a hug'. And she gave me a huge, great hug! Gave her facilitator a huge great hug, and then she stood between both of us with her arms around both of us, and this ear to ear grin, and said, 'I couldn't have done that 20 weeks ago!'

(Interview 8 p.7)

**Jenny** finds mental illness fascinating. She is particularly intrigued with how people can move from being very ill, to gaining insight and then getting better with treatment :

Jenny : You actually see mental illness in its clarity if you like, you see the first rank symptoms, you hear the stuff. Once they begin to settle, because they are so used to being challenged and so used to talking, they will talk to you about what's going on in their heads. They'll talk to you about voices, they'll talk to you about the hallucinations. And to me that's just a wonderful learning experience.

Interviewer : It interests you?

Jenny : It's fascinating, why they get what they get and why they see the things they see or why they think they see the things they see, how they view their illness and how they cope with that. Quite often, obviously when people arrive they don't know that they're ill or they deny that they're ill. And then you see the realisation and then they move on from that. And the treatment for that. I just find that completely fascinating. I mean I just find mental health completely fascinating.

(Interview 9, p.13)

ii. Playing an active part in the transformation of patients/clients is satisfying. Seeing change gives meaning to therapy.

**Stephen** feels a sense of wonder when he can see major changes in patients over time, from their point of admission to their discharge. It is particularly satisfying for him when he can relate any improvement directly to his own occupational therapy intervention :

Stephen : I enjoy trauma orthopaedics because ... there's such a big change. Peoples' pre-admission function is so different, often so different from their past-discharge function that there's such a lot of scope for us. Certainly for me as an OT... Things like road traffic accidents... both lower limb fractures and upper limb fractures and maybe head injury involved as well - that gives you an awful lot to work with. And a lot of satisfaction as you arrive at the end of that time as the person is going home.



Interviewer : What's satisfying?

Stephen : Um, I think that fact that you've seen that person from being nothing, from actually being bed-bound, in pain, etc. and although we are not specifically making that side better, when you see them at the end, being able to function in normal life. To a certain degree you can directly relate that back to your intervention, so it's quite satisfying in that sense.

(Interview 6, p.2)

**Jane** experiences a thrill when she sees her treatment interventions come to fruition - when she feels she has had a part to play enabling someone's growth and independence. It is particularly satisfying when that change has involved a struggle over a long time :

A good week is when things go right for people. You know, somebody gets a stair lift installed. I mean that is the great thrill of being a community occupational therapist... Not just a stair lift, but at the end of the day... It's seeing somebody who has fought for a year of so, has slept downstairs with a commode in one corner. Suddenly their sitting room is all fresh and nice, they've got chairs again, the bed is back upstairs and they're going downstairs! I mean that is the thrill, it's seeing that transformation, knowing that you've had a part in that.

(Interview 5, p.7)

**Mary** likes to feel her clients are getting something out of her therapy - that she is offering something positive and special. The more effort and feeling of challenge on her part, the greater her sense of satisfaction :

I think the very intense clients... And yet sometimes they're the one's who progress... the ones where something has happened and they're not coping, you maybe see four times; they come and go, almost. Then there's the clients that you see who are superficial but go on a long time, and they don't really change that much. And those are the ones who you think well what are you getting out of it? Then there are the intense ones who do progress, and those are the ones where I think, yeah, we've got somewhere here. I suppose with something like that it takes much more effort, it's much more challenging for me, and that's why it's more satisfying, because you feel as if you are actually doing something. Whereas the ones that come and go, a lot of it seems like common sense, and you think well anybody could have done that.

(Interview 1, p.16)

**Paula** likes to get deeply involved in complex treatments where she is able to actively assess, advise and facilitate. The more she is involved in enabling changes, the more effective she feels :

Paula : There's one gentleman in particular, I've been hundreds of times!! And he's never any different! He's never any worse, he's never any better... It's a matter of, 'Oh no, him again!' But there are certain ones that you get in



it's the ones you know that you're going to be involve and interested in... It will either be a young person with a neurological condition, or it will be someone who has had... road traffic accidents, there's brain damage... very often young men... You know that you're going to go along and you're going to be able to do a really good assessment, and there's going to be a role for you. There is going to be quite a lot that you are going to be able to do, or advise, or facilitate, whatever...

Interviewer : Does it make you feel more effective sometimes [Paula : Yes, yes] where there is so much more you can get done?"

Paula : Yes, yes... You know you can... there's going to be result at the end of your intervention.  
(Interview 4 p. 16-17)

**Cathy** enjoys her 'ideal' clients who 'worship' her. She takes pleasure in working with people who are progressing well. She also feels for her clients who are 'stuck' - empathising with their frustration and wondering what they can do.

Cathy : It's nice to have ideal clients that jog along and do everything you say, and hang onto every word, and worship you...! But this particular person...she's done a lot of work herself, and... It's just wonderful to work with somebody that's just doing so well! You know from one week to the next, there is such a big shift, whereas the other people I'm working with are like stuck really.

Interviewer : "And that's frustrating?"

Cathy : "Yes. It's frustrating for them... it's frustrating from me too, but more so for them and you can't help but think about them as well and how it must feel to be stuck... What's life about?  
(Interview 3 pp.9-10)

iii. Our mission is to save patients/clients and offer them a better life. The patients'/clients' achievements are ours.

**Susan** takes pleasure in her clients' achievements. She also experiences a sense of achievement as an occupational therapist. She feels occupational therapists have a range of special techniques to offer, techniques not open to other professionals.

Susan : I'm thinking about a client that I saw last year... She was able to joke on that the very last time I saw her. She was about to move back to ---. She had a pretty grim history : some fairly severe overdoses; a couple of broken marriages behind her, and was about to lose her house; massive debts etc; was moving back to live with her sister... I'd worked with her for 6 months, fairly intensive work, and I suppose had used a more traditional OT programme which had been about setting goals, about actually building up to, you know



spending an hour out of bed each day to actually being able to go out into the village using a set task like 'I'm going to go and buy a newspaper'. I can remember her jesting and saying 'When you first came to me and said well how about us trying this, I thought she's off her trolley!'.. Then she said, 'Now I can't believe how far I have come, and I realise that I've used this structure and it's helped me to be saved. But also I've realised that it wasn't about taking anti-depressants, it was about actually looking at what I could do myself, and doing this has helped me to do that'.

Interviewer : As you're saying that, your face is all kind of lit up.

Susan : Yes, I really felt for her personal achievement. And yes, there was something for me about my achievement as an OT... She was referred within the team as a last ditch attempt and couldn't get on with the consultant psychiatrist.. it was 'She won't see me, she's resistant, she won't come to the day ward.'...

Interviewer : And somehow you succeeded.

Susan : Yes. I'm not saying that's because I'm all magical, but there was just something about being prepared to listen and being prepared to think about a different way, and reminding myself that as an OT I have got different ways that I can use.

(Interview 2 p.28-29)

**Stephen** delights in seeing his patients steadily progress and move on. He feels excited at being able to intervene in a way that fully engages his skills and expertise :

Stephen : He's a double amputee. Unbelievable trauma whilst he was in hospital... they started just above his knee and ended up at the top of his thigh, until they got it right. Just everything that could possibly go wrong went wrong... He had loads of problems with it... just absolutely the most horrible stumps I have ever seen. So, with him there was an awful lot of work... keeping his spirits up... and working through all the issues that were going round with him in a very logical way. It was wonderful!... He was just an amazing guy and as a patient... As we got him better, we had him down the workshop doing activities... we had him down in the kitchen baking... and doing various things on the ward, ADL things and practising bathing and practising transfers, getting him the right wheelchair, getting him the right seating, organising transport for him home so that he could go and visit his wife... and then eventually doing home visits and getting him to the stage so he could go home. It was just brilliant! I mean at the end of the day, this guy is, he's now one of the main members of the support group. And going to pick him up to take him down, it's just amazing to see his whole house adapted in the way that we've sort of set up.

Interviewer : So he's a real OT success story, in a sense [Stephen : Yeah] you have been massively involved and yet it sounds like he's adapted and adjusted.



Stephen : And also OT in the purest sense, from now into the community. He's still under the care of the community OTs, but he's continually having input and things as his function changes and gets better. He's continually moving that next stage on.

(Interview 6, pp.11-12)

**Jane** wants so much for her clients - sometimes even more than they seek for themselves. So she works to help them move on further and reach their potential :

She's a young woman who came from an institutional type establishment with a partner, and they set up home... together. And I was very involved in getting the house sorted out, and getting them settled, and it's her progressing... when she first came out of the institution this for her was the ultimate. She'd achieved her goal in life... And I knew she had so much more potential. She's a bright, vivacious person, she's clever... I wanted her to get more out of life. And it was just working with her. And now she's actually started a training course and she's going to go for a job. And it's knowing that it was me working with her... just talking things through with her has helped and just helped her to go that extra step.

(Interview 5, p.14)

## **Theme 2 : c) Striving to feel effective, valued and appreciated :**

**Changes observed in patients/clients are associated with feeling competent and effective. When patients/clients are stuck, it is frustrating and we question our skills.**

i. It feels good and satisfying to enable change, though how change can be brought about varies.

**Karen** experiences satisfaction when patients respond to her planned intervention, when they progress during a session, from being unable to move to managing to move. Such step-by-step progress gives meaning to her daily work :

Karen : It's always nice to have a patient that you're working on, and you treat them, and they haven't managed to do something, but by the end of the session they've managed to move their fingers and then you treat them a bit more. And the next day they can do something else. Because that gives you satisfaction and you can see the satisfaction it's having for the patient.



Interviewer : Presumably that makes your job worthwhile?

Karen : Yeah, that's what you're doing your job for.  
(Interview 7, p.14)

**Cathy** has struggled to learn and develop new counselling skills, but has been uncertain about her effectiveness. When she sees she has handled a difficult client or situation well she feels good. Seeing progress confirms that her treatment is of value :

I was difficult you know... because that work was quite new to me too, the sort of work we were doing was new, it was all sort of like the feelings that I had to work through myself... Looking back it was quite a difficult time. But I think having said that, I think I handled it in the right way in that we have got through that now and we know where we are, which I can feel good about. I've heard from somebody else that she really likes coming to the sessions and finds them useful... which is good.  
(Interview 3, p.7)

**Mary** enjoys a more structured teaching role in that she can directly link up improvements with her intervention. She feels effective when patients/clients put into practice her advice/teaching. Otherwise she questions whether or not it was her involvement as a therapist which was significant :

Mary : The first time they come in they're absolutely distraught, in a complete mess. The second time they come in they may say, 'I've been thinking about things' and they seem a bit better. And then the third time they come and say, 'I've taken on board what you said'... I find the anxiety management, because it's more structured, it's easier to think, 'Yes, I've given them that information, they've gone away and worked on it.' And yeah, you can see an improvement.

Interviewer : And that makes you feel good as a therapist?

Mary : "Yeah, I think the more educative things, if you like, it's easier to see that they're not on tablets, nothing else has changed apart from the fact that they've put into practice... some of the things you've suggested... I guess the first time I thought, 'This is wonderful! This woman is cured!!' But then I thought, 'Well, what did I do?' or 'It must have been something else. It must have been the tablets' or 'She would have got better regardless'. (Interview 1 p.11)

ii. Receiving positive feedback that therapy interventions are valuable and worthwhile is 'brilliant'. When someone is helped to change, the appreciation and thanks received is encouraging.



**Mary** needs to see her clients progressing and actively taking part in treatment in order for her to keep up her enthusiasm. Clients who make changes allow her to feel she is doing something worthwhile as a therapist :

I guess when clients tend to be a bit flat, if you like, if they're flat and don't make any changes, that's kinda harder to keep your enthusiasm, if you like. I think when people, put the effort in or their part, then you feel as if you are doing something worthwhile.  
(Interview 1, p.19)

**Cathy** enjoys receiving appreciative comments from her clients after they have progressed. She likes these clients best. The clients she finds most difficult to work with are those who withhold any signs of appreciation :

I enjoy the actual sessions with people and especially when they are doing well or you can see them moving on, or even if it's been after a difficult time and they come back and say, 'You're wonderful!', and all that stuff!...I suppose the people I find difficult working with are the people that maybe have what they call personality disorders... This person, you can never win with them. No matter what you do, you bend over backwards and there's no sign of 'Thank you very much for doing that'. I suppose people that show some signs of appreciation, you're bound to like. I mean, it's natural that you like them a bit.  
(Interview 3 pp.6, 19-20)

iii. Positive feedback helps personal and professional development.

**Stephen** describes how he enjoys this sense of mutual exchange :

Stephen : He's very good at feeding back, so you find out a lot about your interventions. He's able to be quite honest and critical of what you have done for him.

Interviewer : So it's not only that you want a pat on your back, saying how good you were, it was like an exchange?

Stephen : Yeah, yeah.  
(Interview 6, p.12)

iv. We despair when patients/clients are 'being horrible' and don't respond.

**Julie** goes through phases of feeling despair when she can't effect change and has no impact on her patients/clients :

Interviewer (in reference to being enthusiastic about OT) : You can lose sight of it can't you?



Julie : You can, you can - when you're short staffed; when all your clients have decided to be absolutely horrible that week!

Interviewer : And when they're being horrible, they're not changing presumably?

Julie : They're not changing on purpose! They're not changing to spite us! And sometimes it seems like you get times when, there's a phrase around here, 'somebody's that way out'. Then you get weeks when whole groups are 'that way out', and you could have created the most beautiful structure in the world, and they just sort of look at it... I went through about three weeks of absolute despair a while ago.

(Interview 8, pp.18-19)

**d) Theme 2 : d) Strategic planning or intuitive magic? : The approach in therapy is carefully planned but sometimes solutions come intuitively and spontaneously.**

All the therapists understand that their relationships with patients/clients have to be carefully managed in pursuit of treatment aims, but at the same time they respond intuitively. They plan their approach to patients/clients carefully, trying to find the most effective line and to systematically implement treatment. But the relationships also evolve spontaneously. The therapists work themselves as treatment tools, consciously and creatively. Both unplanned and strategic choices about the closeness and intensity of the relationships need to be made as these evolve, and boundaries need to be continually re-negotiated

- i. Patients/clients need to be 'handled' to find the best way to engage them co-operatively in treatment.



I observed both **Jane** and **Anne** 'use' themselves in their approach to patients or clients. Each person was handled in a subtly different way. Sometimes they used touch and a gentle, supportive voice; at other times they were bright, straight-talking and full of humour. They responded to each person's needs at the time and so gained the individual's cooperation and commitment.

**Jenny** sees one of her patients as needing to be handled like her own four-year-old girl. She knows this patient needs that extra bit of attention and so she gives it :

I ignore her, and I've really had it...what she reminds me of, very much in the way she behaves, like a child. And having a four year old daughter, the comparisons are quite similar, in that if things don't go her way, you can almost see the tantrum arriving...I've spent an awful lot of time with her and I've...put myself out, even on Saturdays, to take her out and things like that.  
(Interview 9, pp.180, 185)

**Jane** describes how she carefully orchestrates and thinks through her approach, deliberating on both her appearance and behaviour :

I wouldn't use the assertive approach, I'd backtrack and come at them from an unassertive position, because quite often I think it's a control thing...make them feel as though they've got control of the situation...then I think you get further.

**Jane** : I suppose for work...I never dress very formally, I just dress very informally. But for an evening visit yes it would be sort of jeans and, you know, a lot more casual. And in this case I deliberately wanted to make it a lot more casual.

Interviewer : Why?

**Jane** : I suppose to try and get more, a better rapport going with the daughter, because I felt she was seeing me very much as a social services figure, and we were sort of clashing. Whereas I thought if I could go more as a sort of another human being, and again, in some ways we are in similar situations. She's an only child, I'm an only child. So it's to sort of get a little bit more rapport with her, to sort of work around this block that she seemed to have. And it did work to a certain extent. I mean I think we were more honest with each other than we would have been had I visited from the office with my diary and everything with me. (Interview 5, pp. 20, 11)

**Cathy** uses herself and draws on her feelings. She expresses her emotions deliberately, as a tactic to enable clients' to gain insight :

**Cathy** : You know, there's certain things I'm happy to talk about...holidays...playing volleyball...Those are the sort of things I'd feel comfortable about sharing. I think that's okay.



Interviewer : So it's about a balance between sharing personal bits of yourself without sharing necessarily the feelings - that would somehow change the focus onto you?

Cathy : Yeah, yes...I might use how I feel. Like if something happened to somebody...I might say 'I feel angry about that for you'.  
(Interview 3, p.22)

ii. The therapeutic process needs to be carefully planned. Clinical skills and knowledge about grading and adapting our role are used continually within the treatment environment.

**Julie** likens the treatment to planning a dinner party. Much planning and hard work go on behind the scenes to ensure relationships progress smoothly :

I've seen our role as providing the environment in which change can take place. We set up the...best possible conditions, it depends on what stage of treatment you're looking at...and then let things happen...it could be perceived as quite a passive role, only it doesn't feel like that. Like a really good dinner party...all the preparation goes on beforehand. You think about what needs to be done, you think about what your individual guest are going to want. You set all that up beforehand, so what they experience might be quite effortless, but it produces a result you wanted.  
(Interview 8, p.9)

**Jenny** sees her relationships with patients as the fundamental building block of treatment. She views it as a progression which depends on the patients' functioning level. She works at modifying her role and behaviour to suit her patients' needs. So each relationship means something different to her as she slowly works through building their skills :

We intervene at very different times in peoples' stage of illness here. In terms of treating acute people, I think its very much about establishing contact, establishing reality, establishing some sort of relationship with them. And that may be on all sorts of different levels. We have actually brought people down here who have been quite catatonic but have made the decision to get up and come down to the department and who will just sit with us...it may be just you're making something with the clay and they play with a piece of clay, whatever. If that's all they can do that's okay, you're beginning to establish something with them, and building upon that...We may be in sort of full swing rehab with somebody, you know, doing the whole washing, ironing, budgeting...getting them ready to move on to a hostel. So it means, to me in here, it means lots of different things and it utilises an awful lot of my skills as a clinician.  
(Interview 9, p.13)



- iii. It is hard to describe the healing process - the 'magic' of the therapy. Somehow we each offer something special.

**Susan** knows she offers something different and that it works. She uses her skills and wrougths her 'spells'. Doing role plays with her clients, she uses her focus and feels the energy. Somehow the role play comes alive and can be transformed :

If I'm doing a role play with somebody there is that real focus and I feel energy and I feel quite stimulated by it. We can look at it and change it and do different things with it.

I really felt for her personal achievement. And yes, there was something for me about my achievement as an OT...I'm not saying that's because I'm all magical, but there was just something about being prepared to listen and being prepared to think about a different way.

(Interview 2, pp.25, 29)

**Julie** focuses her warmth and energy to 'heal' and 'hold' her patients :

I focus my attention on them, with a feeling of warmth radiating out from myself to them...it gives them a feeling of being cared about, being held, being important.

(Interview 8, p.15)

- iv. Problem-solving is often intuitive and unplanned. It evolves within the therapeutic relationship, through trial and error, whilst we are alert to cues and possibilities.

**Anne's** craft is the intuitive way she works her relationships. I observed her extraordinary capacity to get patients to respond to her and share their concerns. She would somehow understand and know what they needed. I observed this happen on several occasions. Anne got Maisie to open up at their first meeting. Anne was asking the routine assessment questions but in such a way that Maisie felt it was a warm, intimate, friendly conversation. With Mary, Anne somehow 'knew' she needed a kitchen assessment - a real piece of intuitive insight which others (including myself) had missed. With Leonard, Anne was the one who was able to 'get him going'. In just half an hour she 'divined' the cause of his underlying depression (he had recently been bereaved and no one had realised this). She was able to acknowledge it openly and then, at the end, gain his commitment to become involved in treatment.

[See also **Julie's** experience : theme 2 sub-theme e)ii.]



**Theme 2 : e) Practical problem solving - envisioning the past, present, future : Focusing on tactics to overcome functional problems.**

- i. We weave stories about our patients and clients. We look at their current functioning, and then imagine how they were in the past and their potential for the future.

**Jane** goes through an assessment routine, systematically tackling each problem in turn. She assesses what her clients used to do and what they cannot do now. She then tries to imagine what the client needs to be able to do in the future. Sometimes she can envisage a positive future even when her clients are unable to do so. In this way she gives them new goals for the future :

When she first came out of the institution this for her was the ultimate. She'd achieved her goal in life... And I knew she had so much more potential...now she's actually started a training course and she's going to go for a job.

Jane : I always introduce myself. I say 'I'm an occupational therapist, I look at very practical problems that people might be having, I understand that you are having some problems with the stairs or whatever it is, but there might be other problems which we can have a chat about as we talk through'... So we established a relationship and then just sort of generally chatted about what's been happening recently, what's causing the problems ... This was a lady with pretty severe rheumatoid arthritis, longstanding... a lot of the practical problems were upstairs, and since she could only do stairs once a day I obviously didn't want to drag her back up there and then. So what I did was tell her about the grant system, and stair-lifts, and then agreed to come back on a morning before she came downstairs. So the second visit involved the practical bits of seeing how she got on and off the toilet, how she got off the bed, how she got in and out of the shower.

Interviewer : So you actually made her go through those things?

Jane : Yes, I actually did make her go through those things with her husband's assistance. I wanted to see the normal routine, and then I made suggestions... I had lots of equipment with me... We tried out 2 different types of toilet frames, and a raised toilet seat, so she tried them all, and we decided that she preferred the toilet frame and that seemed to be satisfactory, so I left it. I never sort of say to people that 'you have got to have this bit of equipment', and in this lady's case she was a little bit reluctant, so I said, ' Well I think it might be useful. Leave it, try it, and if you don't like it next time you see me I'll take it back.' So we left it on that basis.

(Interview 5, pp. 163, 4)



**Karen** finds it easier to plan treatment if she can ‘see’ the patient as they were before their handicap as it enables her to better envision his or her future needs :

I think one of the hardest things about treating patients who have had strokes is that we don’t know them when they are well. We don’t know what they were like before, and in a way I think that would be quite a help to us, because here we are trying to rehab someone to almost what they were like before, but we don’t know what they were like. In a way it makes it easier for us than it does for the families and relatives, but I do know some patients whom I’ve had in hospital before and have seen them through and got them home before. Because I have had a couple just recently who have come back into hospital with another stroke. It’s easier for me because I know what they were like before, and last time they were very motivated and very keen and very able. And now, obviously it’s a couple of years on, they’re older, you know, not as good. But I can still see that person as they were before, which maybe makes it easier for me to work with them.

(Interview 7, pp.12-13)

- ii. Novel strategies need to be found to help patients/clients move on. It is a challenge which utilises all our skills, but it is worth it as moments of successful, creative problem-solving are good.

**Julie** describes a moment of inspiration when she (in collaboration with the patient) finally found a way to handle a problem :

I thought, ‘I’ve never actually been through the decision-making process with this guy, maybe that would make a difference. If he’s got some kind of conceptual framework he can hang it on.’ So I took him through a very, very simplified decision-making process. And then his face brightened up, and he said, ‘It’s sort of like when you play chess, isn’t it?’ Yyyeeesssss!!! I’d forgotten that this guy is actually a good chess player!

(Interview 8, p.9)

**Karen** describes the thinking process and strategy during individual therapy sessions when they faced the problem of a ‘stuck’ patient and managed to find a way through :

I was taking over a patient of the Senior, as she was going away on holiday for a fortnight. He wasn’t really moving anywhere, so I took him on because she was away. He was transferring to one person and tending to hang off them. So we started just working and cajoling him, and saying, ‘Come on, you can do better, how did you do it before?’. ‘Well I did it like this.’ ‘Oh, right, well, good!’ And really working him through that way, and finding out what job he did, and talking about that, and in a way talking about everything else except what’s actually happened to him and that worked very well.

(Interview 7, p.12)



iii. We need to work with patients/clients through the problems in sequence. It takes time and a systematic approach.

**Stephen** views his patients as needing to work on problems in a set sequence which cannot be rushed. Treatment may need to evolve over a long period. [See theme 2 sub-section b)iii., where Stephen describes his patient who had to have a double amputation]. Feeling under pressure to ensure his patients become independent quickly, he needs their co-operation and motivation if treatment is to progress at a satisfactory pace.

She was immobilised for twelve weeks...it was in the sixth week that I actually went in and started doing things with her. She came off her traction...we started off with her to get her wheelchair independent. We got the wheelchair - double leg rest and all the extras. Then worked on getting her to dress herself and getting her to wash, worked on toilet transfers. These were all over a period of time. It wasn't sort of the case of showing her how to do it. She actually had to practise it... We basically got her independent relatively quickly. But she couldn't go home because she lived in a cottage...until she was able to walk 20-50 yards. We did the home visit with her...I...was getting pressure to do the home visit early, so I did it and she coped. She got herself up and down the stairs and she walked about the flat, she got herself in and out of the shower, she got herself on and off the toilet. We organised various handrails about the flat...And she did brilliantly I tell you!!

(Interview 6, p.13)

**Peter** demonstrated his systematic approach to patients' functional problems in every interview or home visit. He regularly referred to his checklist of questions to make sure the different problem areas were covered. On the home visits, he would take the patients through each room in the house to observe how they managed to carry out their various daily living activities. As problems arose he offered practical solutions (for example, when Maud could not get up from her 'favourite' chair, he produced some chair raisers).

**Theme 2 : f) Being and doing through activity : Striving to capture the creative moment and enjoy the mutual participation.**

i. Our craft involves using activities in different ways and getting the patients/clients involved in 'doing'.



All the **physical occupational therapists** assess their patients'/clients' mobility and functioning by asking them to go through the motions of getting on and off chairs, making cups of tea, and so on. Treatment involves the actual practising of skills, for example, getting dressed.

**Stephen** enjoys getting thoroughly involved in patients' longer terms rehabilitation where the patients participate in a range of activities. He sees this as 'real OT'- putting into practise the skills he learned at college :

Toy making was one of his hobbies at home, so we had him down making some bird boxes...he makes his own bread, so we had him down in the kitchen baking with some of the other patients...it's amazing to see his whole house adapted in the way that we've sort of set up...It was the sort of thing you learn at college how to do, and you feel you've actually put into practice the skills you've learned.  
(Interview 6, p.12)

**Susan's** craft is to work flexibly and be able to draw on different practical activities and therapeutic techniques as needed. She values her ability to be fluid and responsive to her clients' needs :

I think I am good at actually using skills like assertiveness, using skills of developing self confidence. I think, you know, my counselling skills are good and a lot of the practical things that I learnt at college - things like using different ways of allowing people to express themselves, using art as a medium, using things like role-play. I think that that is one of the things that I sort of hold on to that is very different for me as an OT...I can make choices, and I can select from a variety of medium to encourage people, to actually really look at their difficulties. And I think that that is what I am good at, being able to be flexible and fluid in things, and not think, 'Well you've come for counselling, so we will concentrate on the spoken word. Or you've come for...assertiveness so that is all we're going to do'.  
(Interview 2, p.12)

ii. Participating with patients/clients in the activity treatment process is enjoyable and exercises therapeutic skills.

**Jenny** enjoys working in a practical way with her patients. As well as enjoying the actual activities themselves, she finds them an effective tool to assess patients' functioning. Being able to use activity to assess functioning is her craft :

I prefer to work by doing things with people. I really do enjoy the activity side of things. Not because I am very good at any of the activities but because I actually, I actually like assessing their functioning. And that to me



tells me an awful lot. I think I have become quite good at distinguishing peoples' mental states by the way that they function : how they sequence, how they organise things, how they move through activities, how they make choices, how they make decisions.

(Interview 9, p.13)

**Julie** takes pride in being creative in her design of activities and using this to facilitate a group, giving the members a real sense of achievement. This is her craft :

A technique we might use would be something like silk-painting, and we try to do something that you can complete in one hour (which is a real killer!). Something appropriate, something non-demeaning, that can be done in an hour and is fool-proof and looks brilliant like you've just bought it from a craft shop!! This is not impossible, just quite challenging! Now if you're confronted with a yard of silk, it's going to kill you. But if you give people tiny, tiny squares of silk (we actually stretch them over the top of paper cups) and they can just do some squiggles and dots in outline, and then just flood two or three colours onto it, it looks beautiful! And then you take it off and fringe the edges, and you mount it on a card, you have a beautiful greetings card that you could indeed have bought from an art gallery... a good group is people come in and they look at what you're going to do and they say, 'Oh, I can't do that.'... And then at the end of the group they say, 'Look at what I've done!' and they take it away with them.

(Interview 8, p.11)

**Cathy's** craft is being able to set up and run a group with a supportive mix of people. She acts as a sharing, enabling facilitator. She challenges the clients to be active and involved and so motivates them into changing themselves. She uses a mixture of clinical reasoning and 'gut reaction' :

Cathy : It is also about knowing who else is in the group and would it be useful for them, would they find it supportive to work with that person too? And again for me it would be, you know, are we going to get anywhere? Does it feel like we'll get anywhere with this person or not? Are they motivated to change?...Do I think I can use my skills to help this person or not?

Interviewer : That sounds like a mixture of gut reaction and clinical judgement.

Cathy : That's right yes... what I like is quite a bit of interplay between the people who are facilitating the group and the group members too... a sharing type of thing... there's an education and teaching element in it too. We have a theme and this is what we're looking at, and you're trying to get over certain skills to them for them to pick up and be able to use.

(Interview 3, pp.18-19)



- iii. 'Getting a kick' - Special connections are made in the 'doing' process towards enabling change.

**Susan** gets a "kick" out of being able to see changes happening in response to her interventions. When what she gives is taken on board, she feels it as a living thing. She experiences a focus and energy towards creating change. This occurs most often when she takes on a more concrete teaching role rather than being a counsellor where gains are less clear-cut :

Susan : I enjoy... sessions where I feel that I can give something... there's something about giving of yourself. I really enjoy things like teaching a relaxation technique and feeling that I've got something really concrete that I can actually give. And I enjoy the educational part of some of the work that we do, or feeling that I've got something to share, and actually allowing somebody the opportunity to learn something new... Its the bit I really get a kick out of.

Interviewer: Why is there a kick?

Susan : Because I can actually see it.

Interviewer: You can see the improvement?

Susan : That's right. So say it's about a relaxation technique, and I've spent time in the session. I've worked with the person and demonstrated what its about and gone through it with them; and then they go away and practise it... If they say, 'That was really good.', then I feel that was good, and its something that I took as knowledge from my head, and here it is in the living thing, and that feels really good... I can feel, in a practical session, that we've done something and it is finished. Whereas the thing about counselling is that it's never finished.

Interviewer : And it's more difficult because there isn't a focus?

Susan : Yes, or not even that, I think it's because there isn't the same stimulation that I personally get from the actual activity or the task if it's there. So, you know, if I'm doing a role play with somebody there is that real focus and I feel energy and I feel quite stimulated by it. We can look at it and change it and do different things with it... The thing about something like counselling sessions is that it takes longer to see the actual... whether or not they are effective, because the change may be a long time in coming. Whereas if there's a focus on actually doing something or a skill or an activity, I'm not saying that the change comes quickly, but you can actually see it.

Interviewer : And change makes you feel effective?

Susan : Yes, yes.  
(Interview 2, pp.24-6)



## **SUMMARY of theme 2**

The therapists all have a mission to 'make a difference' - and they all believe they can. Whilst change means something different to each therapist, and they experience different satisfactions during the therapy process, all feel satisfied when they can enable a patient/client to progress. This process of change can involve much challenge and struggle for both therapist and patient/client, but this makes it even more exciting when there are positive outcomes. Equally, when the patient/client is 'stuck' the therapists experience their work as frustrating and can feel they are ineffective or have failed in some way.

The therapists enact their craft using themselves as tools in treatment. They focus on their patients'/clients' problems, envisaging past coping and present/future needs as part of the problem-solving process. The therapeutic potential of 'doing' in activity is harnessed as the creativity and mutual participation are enjoyed.



### 4.2.3 (Theme 3) :

## **NEGOTIATING THE BOUNDARIES : THE CARING-POWER RELATIONSHIP**

Whilst each therapist evolves different sorts of relationships, both strategic and spontaneous, with each patient/client, certain common strands are discernible. The therapist-patient/client relationship can be understood as simultaneously a caring and a power relationship. These two dimensions intersect in different, often contradictory, ways.

All the therapists experience their relationships with patients/clients in terms of ‘being caring’ as well as having a ‘duty of care’. They feel degrees of caring, compassion, and even love. They also care by feeling concerned about their patients/clients and wanting to help, though what this means to each of them varies. They share in and celebrate successes in treatment and feel saddened by failure. But alongside this caring, the therapists grapple with a power dimension which is embedded within all their relationships. Whilst they direct and control their patients/clients, they also seek more collaborative mutual relationships and they try to deny power. But they become aware of the inequalities of the relationship when patients/clients are excessively dependent on them. More generally, the therapists recognise they are in a position of authority and they act on this by giving directive instruction and advice. Sometimes this authority is challenged as the therapists and patients/clients battle for the upper hand. In extreme cases, the power balance shifts and patients/clients themselves may become abusive. With these ‘creepy’, threatening patients/clients, the therapists can feel an overwhelming sense of distaste and fear, so they manoeuvre to keep safe.



Six sub-themes have emerged in this context :

- a) **Being caring, sharing and empowering** : We want to give of ourselves and share our professional skills and knowledge.
- b) **Intense giving or pragmatic detachment?** : Negotiating personal/professional boundaries of intense involvement versus maintaining a professional distance.
- c) **Trading control for collaboration** : Relationships are best when egalitarian.
- d) **Being sucked dry** : Patients feel like needy, dependent children when they demand nurturing or force authoritarian responses.
- e) **The battle for control - the patient as adversary** : It's a battle to control patients/clients.
- f) **'Creepy', threatening patients - keeping a safe distance** : We manoeuvre to avoid abuse.

**Theme 3 : a) Being caring, sharing and empowering : We want to give of ourselves and share our professional skills and knowledge.**

- i. 'Caring' means feeling warmly concerned about patients/clients and wanting to help. It means sharing in the patients'/clients' suffering and being there to lend support and comfort.

**Julie** is concerned about and 'loves' her patients. For her, the relationship is special. When she is with someone she tries to give them her full focus and somehow share her 'healing'. This involves sharing her warmth, to help her patients feel important and cared about :

Julie : When I'm actually with somebody, I - Over the last few years I have become much more aware of my emotional response to them, and the people that I work well with, are the people that, this is going to sound really really corny. Actually, I don't care! People , people that I love, that I love in a very very specific way, I really care about them. No it's more than caring because it involves an emotional warmth coming from me. It is almost a technique that I use to focus myself on people. And this is more in individual work than in group work (it is quite hard to do it with a group, though I am getting better). I focus my attention on them, with a feeling of warmth radiating out from myself to them. And somehow that really helps me to focus myself and I hope it gives them a feeling of being cared about, being held, being important.



Interviewer : Is it kind of tuning in to them at an emotional as well as head level?

Julie : Umm, yeah, very definitely.

Interviewer : And so when you kind of do that focusing, with whichever patient, are you saying that because you are doing the focusing you feel warm towards them?

Julie : ...I couldn't manufacture warmth.

Interviewer : So which are the patients you feel that with?

Julie : Virtually all of them! There are very very few people who I can not feel that for.

(Interview 8, pp.15-16)

ii. Seeking to connect with, and gain from, patients/clients through working together :

Having a mutual relationship is important.

**Jane** sees her role within the therapy relationship as being a caring, constructive, empowering 'mother'. In return she gains positive feedback and much fulfilment. She acknowledges that she needs her clients - they are her children (as she does not have any herself) and she misses them when she is away :

I think what I get out of my work, I've often asked myself this and analysed my feelings, and one of my very strong points is almost a parenting ability. Not in a smothering way, but I think in a quite constructive way. So I can sort of help people to develop and sort of, you know, bring people out, give them choices, and that is what I get back from my work. And I think it's lots of development for myself, as well, because I don't have any children, I don't have a family, so it's almost a substitution process - but I think in a constructive way. I know a lot of professionals tend to be very overpowering and very sort of mothering. I'm not like that, I've been told 'no, that isn't you', it's more constructive. But yes, I do get a lot of feedback and a lot of fulfilment from that. If I'm off work for a fortnight or so, I actually miss it!

(Interview 5, p.13)

**Mary** sees herself as 'rescuing' desperate clients. She feels sorry for them and wants to help them get out of their bad times. She likes feeling that she can do something and that they appreciate her. But she also feels she needs to get something out of treatment (like positive feedback or pleasure in the relationship). Treatment is experienced as unsatisfying without some give and take :

At the beginning you kinda think, 'poor lady, you know, she really needs a lot of help'... The first couple of times you go you think, 'poor lady'. And then it gets to the stage where it's, 'God, it's like a record going round and round!'



And that's kind of difficult, when you feel as if you're not getting anywhere... I'm kinda really questioning why and what are either myself or the client getting out of the treatment.  
(Interview 1, p.5)

iii. It is important to be non-judgemental and accepting, and to value patients/clients.

Patients/clients need to be enabled to be more confident and independent.

**Julie** believes it is important to be client-centred and non-judgemental. She strives to show she accepts her clients and seeks opportunities to empower them, for instance, encouraging them to make their own decisions. She takes pleasure in her patients' progress and growing sense of agency :

Julie : I have a client at the moment who a long time ago committed an incredibly serious crime and she still carries the scars of that around. and for a while she didn't know that I knew. And comparatively recently she told me and then she said, 'ah damn! I shouldn't have told you that because now -- you'll reject me, you won't want to know me...'. she was going on about it and I was trying to interrupt her, 'hey up, listen to me, I know, I have known, for a long time! And it hasn't changed the way I have responded to you at all.' and she sort of said, 'Oh, hey, good point'.

Interviewer : Had you not known when she told you, do you think it might have had an effect?

Julie : No, I don't think so, no.

Interviewer : So you see yourself as responding to the people as they are being?

Julie : As they are here and now.  
(Interview 8, p.17)

They had a choice of shells, or elephants or butterflies. The other people in the group all fancied butterflies. He'd been looking at butterflies and elephants, and was saying 'Well I guess I'd better have butterflies'. 'Does that mean you want butterflies, or you think it's more convenient for me to do butterflies, because I'm not worried?'... 'So I could have elephants if I wanted?' And eventually, 'I want elephants'. That was brilliant because he'd chosen what he wanted!!  
(Interview 8, p.8)



### **Theme 3 : b) Intense giving or pragmatic detachment? :**

#### **Negotiating personal and professional boundaries of intense involvement versus maintaining a professional distance.**

- i. Relationships with patients/clients can be superficial or intense. Sometimes the relationship is transient, and forgotten quite quickly; at other times emotions are involved as the relationship develops over a longer period.

**Jenny** describes her evolving relationship with one patient with whom she has a deep (and deeply significant) relationship. Their relationship has shifted between Jenny offering care by doing practical treatments and negotiating an intense emotional relationship :

Jenny : I arrived in the unit days after P did. So, as I was saying, we've always sort of worked with her and she has attended groups and very much, very practical based groups, also some relaxation and stress management stuff... She has now moved on from that, and there are times she says when she still feels like cutting up, but she doesn't. She talks more about it. She does it occasionally, but its very superficial. And then we always go into the guilt, "Oh I've done it and I've let you down" and all the rest of it. She is very abusive and manipulative in the way she runs her own relationships with people. Um, and, you know, like I've spent an awful lot of time with her and I've like put myself out, even on Saturdays, to take her out and things like that. And, um, you know I could walk of here now and she'd just like glare as if I've dropped off the end of a bus --. She's very manipulative, very abusive in her own way.

Interviewer : Do you feel she manipulates you as well?

Jenny : To an extent, to an extent. But she sees me very much as a part of her life I think and part of her treatment... There was a situation the other week whereby I'd heard half the story and I clarified some of it with P-- and it wound her up. Now not at any point during all this did she blame me. And it was my fault, I should have said something --. I knew as soon as I had said it "Oh no, here we go"... she never at one point blamed me, she shifted the blame around everybody else and I was sat there saying, 'Well look it is my fault. I will accept responsibility for this P' 'Oh no no no, its not your fault, its so and so's fault!' 'Well that changed from yesterday!' So its obviously important to her, that she will protect...our relationship, to that degree.  
(Interview 9, pp.9-10)

**Paula** can become so involved with her clients that she shares in their pain. But it takes so much out of her emotionally that she has to try to protect herself by being



more distant. She shows her caring by focusing on practicalities and easing her clients' physical or environmental difficulties :

Paula : We shared a lot of things, you know, they both shared a lot of things with me about their life, and whatever, and I really did get so involved with those people, that when he died, ohh it was just horrendous, it really was!

Interviewer : I can see you're upset even now.

Paula : Yes, oh I am, he was so nice, and yet his death was so...how she described it...that's why I got upset, because she described it in such detail to me...I went to see her afterwards, immediately afterwards, it all just came pouring out. And it was so sad that..that was very very hard. And that made me realise I can't do that, because so many people do die, that you go and see, and you need to be conditioned...If you really sat and thought about it, and really..it would, you couldn't do what you do...you have to go in on a certain level...I go in with the attitude 'right, what can I do for these people? How can I make their situation easier?'

(Interview 4, pp.13-14)

**Jane** also becomes involved and she takes real pleasure from her deeper contact and connection with some clients. However, she also worries about her clients' condition and she becomes anxious about losing them and, in the extreme, them dying. On one occasion she was observed to stay with a client, whom she was concerned about, during the evening and carry out a range of tasks (such as bathing the client and making her comfortable in bed) - tasks which were way beyond the call of her occupational therapy duty :

He's a gentleman in his late 60's. He had a very serious road traffic accident approximately 30 years ago which left him with a slight head injury, which meant he had slight memory problems anyway , and emotional lability, to a certain extent, but when I first came across him he was still walking up and down stairs, you know, a lovely very gentleman's gentleman, a real ladies man, he actually kisses the hand! You know, and really just very very nice. They were a lovely couple, very caring of other people and very supportive. And he's deteriorated very rapidly... There's a picture of him downstairs if you want to see it, with Fergie!... When he dies I think [pause] I'll cry my eyes out.  
(Interview 5, p.17)

ii. Striving to get close whilst not too emotionally involved : It's a struggle to define personal versus professional boundaries, and negotiate levels of intimacy. Personal contact makes work satisfying and rewarding, but it is also a source of stress and pain.



**Jane** struggles not to get too involved with her clients but cannot avoid doing so : that is the sort of person she is. She sees them as 'friends' and worries about them when she goes home at night. But she also knows she has to draw boundaries otherwise both her personal and professional lives will be negatively affected. She understands these boundaries are necessary but part of her is sometimes tempted to deny them.

Jane : Yes, I've had some very close relationships with my clients, almost to the extent where you do become friends. There's one gentleman... who after I left and came down here, I stayed in contact with and with his family, and he became a friend. It's not often that people will cross over that boundary with me. I think part of that was because I did move, and he was no longer my client, so that was a lot easier.

Interviewer : So while you were working with him as an OT you wouldn't be friends as well?

Jane : Not normally, I don't think that's a good idea really...it makes the working relationship difficult, I think.

Interviewer : Why is that?

Jane : It's to do with your role, and where you are providing a service. If you are then sort of a friend as well, I don't know, maybe it's not for everybody, but I'd find that a little bit difficult. And I'd find it also something that could be misconstrued, because, say for example I was very friendly with Mrs Bloggs and had given her a living gas flame fire and somebody could say, 'well that's because she's always going out of an evening with her', or whatever. I think that is dangerous ground to get into. I prefer to keep a slight boundary anyway. (Interview 5, p.13)

There is a danger of me becoming very emotionally involved with my work. And yes, I'm aware that sometimes I do that, you know, sort of worry about people at home. I try not to, but I think again that it's almost inescapable, that's the sort of person that I am.  
(Interview 5, p.16)

**Karen** negotiates different levels of intimacy with her patients. Her professional role requires her to touch/handle patients and deal with personal bodily functions. This has created tensions, even embarrassment, for her in the past when her personal experience and training were limited. Now she is less self-conscious :

Karen : A lot of physical contact there is all the way through the therapy which can create quite a lot of problems for the patient...and obviously for OTs it can be quite daunting, because most of our training is hands-off, respect for personal dignity, etc. Whereas for the physios, they strip them off the whole time. But once you've been in neuro you begin to, it doesn't become a problem for the staff, but you have to be aware that for some patients it is.



Interviewer : How did you negotiate that, a couple of years ago when you first came into neuro?

Karen : I'd actually worked on spinal injuries so I was used to having to deal with catheters and convenes...It was horrendous!...I felt mortified and so embarrassed, and, you know, pretended there wasn't anything underneath the sheet and everything, and hold the towel down till you got the pants off, and the towel gets stuck in the pants, and your embarrassment actually makes it worse for the patient.

Interviewer : What's the embarrassment about?...

Karen : I think quite a bit of it is your upbringing because my upbringing was fairly modest, and lack of experience. I know at college they dwelt quite heavily on privacy, but.... we didn't have much physical contact at college, so that really didn't prepare me for handling patients, and handling patients fairly intimately. Whereas on the physio course they're forever taking off their tops, and ...getting in there and get your hands under peoples' armpits and everything, so that is quite a problem, because you need to be able to handle people to know how their body feels, for you to, you need to know whether it's right or wrong, and that takes a bit of picking up, really. It's very daunting at first.

(Interview 7, p.6)

### **Theme 3 : c) Trading control for collaboration : Relationships are best when more egalitarian.**

#### **i. Patients/clients should actively participate and collaborate in treatment.**

All the therapists, in their different ways, need their clients to be actively involved and participating. They believe treatment has to be a partnership.

**Stephen** experiences a sense of being in a coalition with his patients as they unite against the authority of the doctor. When he is under pressure to produce a result for the doctor he is dependent on his patients to also work hard and produce the goods. He feels satisfied and proud when they can achieve positive results together :

We were called in by the consultant who took her off traction saying, 'This lady must be wheelchair independent'. So we got the wheelchair...We basically got her independent relatively quickly...I really had my doubts about how she was going to cope but I was getting pressure to do the home visit early, so I did it and...she did brilliantly!!



(Interview 6, p.13) [see also theme.2 sub-section e).iii. for a fuller quotation]

**Susan** needs to get something back from her clients, to feel they are working together.

The clients that I really like to work with are clients who are able to put something in, or are wanting to put something in, who don't just expect a professional person to do everything for them. They're the clients that I feel like you get something back. Where it feels very much that I can engage in that partnership where we are working together rather than you doing it for them. (Susan, Interview 2, p.26)

**Cathy** believes the clients need to be active and that she is only there to support them and help where she can :

It's nice to have people that join in and participate... One of the things that I say to people is..., 'the fact of the matter of life is such that in mental health I cannot change it. I cannot get hold of anything and change it. If it was your arm that was broken, then I could flex it up and down and we'd get an activity and the rest of it. But I can't do that for you and you have to be the active person in this. I'm there to support and help. (Interview 3, pp.18-19)

## ii. Patients/clients need to be empowered.

**Jane** tries to enable her clients to feel they are in control even when the reality is that she is in control. She feels its important to empower them, and believes this is best achieved by adopting a non-assertive approach :

I wouldn't use the assertive approach, I'd backtrack and come at them from an unassertive position, because quite often I think it's a control thing. People are terrified of losing control and if you could sort of go in from a less dominant position and make them feel as though they've got control of the situation and have got control of yourself, then I think you get further. (Interview 5, p.20)

**Cathy** believes she needs to give something of herself to balance inequalities, and so shares her feelings :

The importance of needing to...give too...it's all very well me getting all the personal info and me not sharing anything at all. So it's about when it's the right time to do that, and what's appropriate. ...They're looking after me then. (Interview 3, p.22)



**Theme 3 : d) Being sucked dry : Patients feel like needy, dependent children when they demand nurturing or force authoritarian responses.**

i. It is hard to resist the transferences of the patient/client as a dependent child, and sometimes we cannot. As 'parents' we feel guilty about not giving enough or feeling angry. We also experience a tension as we do not want to give too much as that works against the aim of enabling independence.

Jenny occasionally experiences her patients as children (like her own four-year-old). Patients can be seen as demanding and dependent. They get jealous, have tantrums and need her attention. She struggles not to act like an authoritarian parent in response and she has to remind herself to be empathetic :

Jenny : She is still very, very dependent on people. You know, even to protecting the relationship to that extent. Extremely dependent on her doctor and extremely dependent on like her primary nurse...

Interviewer : What does it feel like to have somebody like that be so dependent on you?

Jenny : It's very weird at times. Um, very weird, even down to the fact that obviously we work in a mixed sex environment and if I'm stood talking to my colleague, she doesn't like it, especially if it's one of the younger, more attractive nursing staff. She doesn't like it and woe betide me if I don't see her walking past, sort of, then I get messages like 'P-- would like to speak to you' and it all turns out that 'you were talking to so and so and you didn't acknowledge me'... So it can get a bit wearing at times.

Interviewer : Does she want you as a sort of like a mother, or more as a lover, or even deep friend?

Jenny : I think it's friend and that nothing should betray that...we do have a lot of very young really attractive nursing staff on the unit, and quite often she'll get attached to them.... She's a 27-year-old girl and there are a few she has sort of had ..crushes on almost... Yeah, woe betide me if its one of 'them' and I ignore her, and I've really had it...what she reminds me of, very much in the way she handles things and the way she behaves, as a child. And having a four year old daughter, the comparisons are quite similar, in that if things don't go her way, you can almost see the tantrum arriving. And it, sometimes its very difficult for me not to treat her in the same manner as I do a four year old in the



supermarket... And she is extremely trying and she's extremely wearing because its like one step forward, ten steps back...

Interviewer : ...She's clearly a difficult person, but it also sounds like you've got a fondness for her(?)”

Jenny : Oh, most definitely.  
(Interview 9, p.10)

**Mary** sees some of her clients as demanding and constantly needing her reassurance. They grab at her - ‘suck her dry’. Sometimes it feels she will have to ‘give’ endlessly and she feels tired. She views the process of treatment as ‘weaning’ these clients off her and therapy. She sometimes feels guilty when she can’t give enough :

It just kinda makes you feel a bit uneasy, because it’s almost like she’s setting you up, that you have to be there every time she needs you and be there forever and a day...she needs constant reassurance about this, and gets very anxious...And she wants you to make a decision on her behalf the whole time...she sort of sits the chairs so close together, you’re always within touching range, and she sort of grabs your hand...Sometimes you sort of think, ‘Well, God, you know, get a grip!’...it’s things we’ve been over before, and we’ve talked through...and then you can go next time and there’s all this drama again...it’s like going over old ground again...If I’m feeling tired when I go... it’s very difficult to concentrate and be constructive and positive, when it’s like somebody’s whittering. You think, ‘I’ve heard all this before’.  
(Interview 1, pp.5-6)

ii. 'If only they would comply with the logic of the treatment'. Sometimes the patients/clients play games, resisting our direction and expert advice as they challenge our authority.

**Stephen** is clear that there comes a point where he does not negotiate with patients. He gives his instructions (particularly regarding safety precautions) and expects his patients to be rational and follow the advice :

Interviewer : So there isn't ...lots of negotiation with the patient?

Stephen : Not really, because the type of injury they've got is quite dictative of what they must do. I mean you can negotiate with the patient for a while on it, but at the end of the day they mustn't flex beyond 90; they mustn't internally rotate; they mustn't adduct or the hip will dislocate and they'll go back into hospital.

Interviewer : You usually don't get too much trouble from the patient, by the sound of it.



Stephen : If you do, you tell them sort of what will happen, the implications of it. They don't usually, so that's fair enough.  
(Interview 6, p.9)

**Karen** similarly has to be directive and sometimes push patients against their will. She acknowledges they may well perceive her as coldly evaluating or acting like a 'firing squad', which is something she feels mixed about. She sees the patients as occasionally responding to her authority position in naughty, mischievous ways :

Karen : Unfortunately dressing practise is seen as a test, an assessment, and the patients aren't particularly keen, they don't like having labels on them, they groan and everything.

Interviewer : Labels?

Karen : We put labels on their bed so that the nurses don't dress them. Subtler ways don't seem to work. Even the labels on the bed don't always work, the patients are often still got up and washed and dressed... The label's been hidden behind the pillows when they come to get people up, or the patient says, 'No, I'm not on dressing practice'.

Interviewer : So that's the patient's sort of playing?!

Karen : Yeah, sometimes they disappear as well, which is quite interesting. But that doesn't happen very often.

Interviewer : I've got this image of the OTs and physios with a whip!

Karen : ...sometimes it's almost like a battle, trying to show the patient's what they are doing to themselves by doing too much.

Interviewer : ...sort of you against the patients(?)

Karen : Like a firing squad! It makes us sound awful!...I think the patients might view it like that.  
(Interview 7, pp.7-8)



**Theme 3 : e) The battle for control - the patient as adversary : It's a battle to control patients/clients.**

- i. It can be a battle to control angry feelings and not get aggressive. In the end, the patients/clients cannot be coerced and we must accept their decisions.

**Paula** has to work on not being defensive and angry :

Paula : You got all the flack from the daughters, 'we don't want a stair lift, we don't want this, we don't want that'. So, it was explaining to everybody, and in the end I thought 'Oh no' ...you can deal with one person going, you know, going mad at you, but I find it hard... it's all at you, and you think, 'I didn't ask for this, you know, this defensive attitude!'. But you learn to deal with it...because it's so easy to become on the defensive yourself, when you're getting a lot from people. I've learnt to literally just to sort of state my situation, and state where I'm coming from, and leave it at that, really. 'I can only explain to you the...role that I've got to play, and how I've got to relate to you'.

Interviewer : When you say it would be easy to become defensive, do you mean to kind of get angry yourself, and say, 'Right, well, stuff you'?

Paula : Well yes, because in some situations you just think 'God! You know, I wish you'd listen to what I was saying. You're not, yes you're hearing what I'm saying but you're not actually listening and taking it on board'. And with some situation you feel like saying, 'Well, if you would just listen to me'.  
(Interview 4, pp.12-13)

**Stephen** experiences power battles where he feels aggressive but he knows he has to turn away and accept he cannot control every situation :

Stephen : A lady on the ward yesterday could not wait to get home, and dumped all the equipment at the nursing station and said she didn't want it. I just did a document to the effect that she'd done that. I don't think there's anything really we can do. She's been advised by four professionals.

Interviewer : I guess at some point it's up to them as long as you've given them the clear advice(?)

Stephen : Yeah. I mean, quite often patients choose not to take it.

Interviewer : "How do you react to that?"



Stephen : I get quite aggressive sometimes, because I feel that they're - it's a bit of a power thing...I've had words with the patient to try and persuade them, when I've walked off at the end of the day, you feel that it's just the patient's choice, and I sometimes feel well that would been me if I was on the ward, I'd be sort of saying I didn't want to do it as well....I think it's all part of the job...it certainly makes the job easier now that I've accepted the fact that patients sometimes don't do things. Whereas as a basic grade the patients had to do things or else it was my fault.

Interviewer : Right. So you've kind of distanced yourself and you've got a clear sense of where the boundaries of your role are and you can take responsibility for that.

Stephen : Yeah, Yeah

Interviewer : What's this power thing you're talking about, is it that staff are in power positions over the patient?

Stephen : Power is too strong a word - um, authority.  
(Interview 6, p.9)

## ii. Feeling manipulated, set-up, damaged and powerless

**Jenny and Mary** each describe two abusive patients/clients who have made them feel powerless, helpless and without control :

You always have to be very assertive with him, but it's got to the point where no matter how I deal with him, it makes no difference, because he still insists on doing it. And it is very much about me.. as a woman and you know, the women who can... control him if you like, and he doesn't have a problem with them. They are a lot older than I am. And yes, they're able to set their boundaries, but then he's obviously neither as attracted or as, you know having fantasies about or whatever. Um, you know, he even does things like, there's a large observation -- windows from the other ward, and even if he can't physically get to you, he'll stand there and rub his groin and drool .. at the window and things like that. Its those invidious bits of behaviour. He'll crawl across the floor to get to you.  
(Jenny, Interview 9, pp.11-12)

The thing is I don't mind if they're demanding but they get somewhere, but I have a client who is very demanding and very abusive, and was not willing to put any commitment to a change in. And that's when you feel frustrated... she kinda said, 'I'm going to put in an official complaint about you' and all the rest of it. And I just said, 'You know, do whatever you want.'  
(Mary, Interview 1, pp.7-8)



### Theme 3 : f) 'Creepy', threatening patients - keeping a safe

**distance : We manoeuvre to avoid abuse.**

i. The threat of abuse is always there around the corner.

**Mary** feels she has been damaged by a verbally abusive patient and that there was nothing she could do about it to help or defend herself. So she made use of the final sanction to discharge the patient :

She basically set me up like she did everybody else...I ended up having to discharge her because she's so abusive - she's abusive to everybody in the team and I just felt 'What can you offer somebody like that?'.  
(Interview 1, p.7)

In the context of her forensic unit, **Jenny** recognises her particular risk of being attacked both physically and sexually. She describes her defensive manoeuvres in the face of such a threat :

He fantasises an awful lot and... it got to the point where his boundaries were breaking down and...in the corridor, and you'd have to pass, he would actually come into the office, which they know they are not really supposed to do, and he would interrupt phone calls... But he is much more covert about it really. But again I am very much aware of what's going on in his head. I don't isolate myself with him. I have very little to do with him. The other patient, I am particularly wary of, is very different. I knew him when I worked in local services...I think because of that connection, he's then twisted it round in his head that most of what's happened to him subsequently is my fault. And so again I just had to keep a very wide berth from him.  
(Interview 9, p.12)

ii. Dealing with patients who have violent sexual histories is threatening. As women, somehow the threat of being sexually assaulted or 'invaded' is more frightening and distressing than the threat of straightforward physical violence.

**Julie** and **Jenny** both understand that as therapists they run a risk of being hit and abused. They are more frightened about being sexually attacked. They feel this threat more personally - as women, not just as therapists :

I have never, touch wood, been hit and never been threatened. But you accept that a thump is a thump, with him it's not going to be a thump, it's going to be something sexual. Now any woman can put their hand on their heart and say that's their worst nightmare, is to actually get attacked in that way, whether they are working in a secure unit or not. Um, and that's the way that he would



attack. He would not attack in a physical way. So its a very different feeling and its a very different, um, fear if you like, in terms of somebody wanting to hit you... One of the patients, his offence was rape and he is very inappropriate with females. You know, if you met him now he would be totally inappropriate with you. You are a very new female and he always sort of tries it on with new females.

(Jenny, Interview 9 p.11) [see also section D. ii.]

Julie : I could not work as this guy's key therapist. I couldn't tell you what it was about him, because he was superficially quite pleasant, but he just made my skin creep. He used to have serious problems with proximity in that he would get too close and he would position himself so that he trapped you at your desk or in your room. If he was in the doorway he would be standing with his hand across the frame, so you couldn't get out. And also he wore Brylcreem! I wasn't actually alone. None of the female members of staff here or on the ward felt comfortable with him.

Interviewer : Were you threatened by him like it was a sexual thing?

Julie : There was a sexual element to it because none of us felt physically threatened. I could have --- over my knees, he was only little! He was probably verging on having emphysema or something, so - it was a psychological threat rather than a physical one... There was something unwholesome about him..

(Julie, Interview 8, p.16)

**Jenny** takes precautions and ensures she is well protected - a support which offers her a measure of comfort. But she still waits for the time one particular 'creepy', 'predatory' male patient will 'get her' and she is frightened :

He's very, for want of a more clinical word, extremely creepy. He will come up, want to touch you or to touch you inappropriately... He's a bit predatory in that he will follow you down corridors. We, obviously, we don't walk down the ward on our own but he will follow you down corridors. He had actually... preyed across the gym (we have like a gym area on the ward) crept up behind me, cause he's very quiet, when you think you are sort of off the ward and you are safe he'll have you cornered really ... because I am known to be at risk, I'm watched a lot, which is really comforting .

Interviewer : Why are you known to be at risk?

Jenny : Because every time he comes into contact with me he will do something. He will try to touch me, he will make a comment... this time that he got me cornered in the gym he said, 'They can't watch all of you all of the time, or they won't watch all of you all of the time, and I'll get you.'... That was about 18 months ago, so I am still waiting for this to happen.

(Interview 9 pp.10-11)



## SUMMARY of theme 3

The relationship with patients/clients, how it evolves and what it means to the therapists is both complex and ambiguous. The relationship is seen as being of central importance in and for therapy, but what this actually means for each therapist varies. Also the relationships are enacted in different ways. Sometimes therapists strive for relatively short term practical, task-orientated relationships where care is demonstrated by pragmatic or technical assistance. At other times therapists become intensely and emotionally involved over a long period. The relationship is additionally complicated as the boundaries between therapist and patient/client remain mutable - constantly open to re-negotiation and change. The therapists all struggle in their different ways to negotiate how enmeshed or detached they need to be.

Although each relationship is experienced differently, there are also common understandings. All the relationships are experienced as multi-layered where dimensions of care and power interact in different, and often contradictory, ways. Whilst the therapists feel warm concern for their patients/clients, they also experience negative and angry feelings which have to be strategically managed. Whilst the therapists want to control and direct their patients/clients, they also aim to empower and have more equal relationships. Whilst therapists 'care' and seek mutual collaboration, they do so in the context of a relationship that is essentially instrumental and unequal.



#### 4.2.4 (Theme 4) :

### **SAFE HAVEN OR BATTLEGROUND? COLLABORATION AND CONFLICT WITHIN THE TEAM**

Tensions between caring and power are also experienced in terms of team relationships. All the therapists locate themselves within the context of two distinct teams : the multi-disciplinary team and the occupational therapy team. Both these play a fundamental role in the occupational therapist's life world in that they are important sources of identity and meaning. What the teams (and the roles and relationships contained within them) mean to each therapist varies, but certain experiences are common.

All the therapists identify one or other of the teams as being a prime source of mutual support, respect and esteem, as team members collaborate with each other in therapy and decision-making. The team is thus perceived as a sharing, caring 'family' which offers a safe haven from the stresses of contact with difficult patients.

But, as in families, relationships and experiences are mixed. The individuals concerned engage in multiple relationships reflecting different degrees of collaboration/closeness and resistance/distance. The teams may be viewed as a battleground, as a source of conflict and tension - even to the point of being experienced as destructive or damaging. The team may well be split along ideological lines [see theme 1 sub-section c)]. Further, the therapists see themselves as being in competition with others as they jostle for recognition and attempt to carve out their role boundaries. In their different ways the therapists are engaged in a battle to be respected and valued by other team



members. Also, with too many referrals and not enough time, they feel pressured and unsupported by their management hierarchy, experiencing a sense of powerlessness in the face of intense change, resource constraints and redundancy threats. The difficult realities of operating in a team sit in contrast to the idealised images held by some therapists that the team should offer continual, unconditional support.

In this context five sub-themes have emerged :

- a) **Caring for each other** : The team is a source of identity and support. It feels good to share and co-operate in team decision making.
- b) **'Good' colleagues, 'bad' colleagues** : Levels of trust, respect and appreciation vary throughout each team. We collaborate with some people and are more tense or distant with others.
- c) **Sibling rivalry** : The team is also a source of problems and conflict where we compete with others over territory and vie for recognition.
- d) **Threats and imperatives - assaulted by the system** : The demands of the wider healthcare system are a constant pressure.
- e) **Ideal images versus tough reality** : It is hard to hold on to past ideals and images of the team when the team feels divisive, destructive and damaging.

**Theme 4 : a) Caring for each other : The team is a source of identity and support. It feels good to share and co-operate in team decision making.**

- i. The multi-disciplinary team, means sharing in decisions and jointly negotiating treatment plans.

**Mary** identifies with her community mental health team. The weekly team meeting (where they negotiate who sees which clients) structures her day. She feels they have an awareness of each others' skills and expertise, a feature of the teamwork she enjoys:



I work in a multi-disciplinary team with community psychiatric nurses and social workers and there's also medical input and a psychologist as well. Basically the way we work here is we have a meeting each week and anybody can pick up any referral... I think it's nice because although we all do similar sort of work, each profession has its own sort of speciality... So there's that recognition, which is good.

(Interview 1, p.1)

ii. It is important to collaborate on treatment planning as other professionals can inspire confidence and ideas. It is a relief to share with others. Also, team collaboration means safe practice, even survival.

**Stephen** understands team liaison is important. He is accustomed to working alongside others and he uses others to help work out required treatment :

My immediate reaction was 'Oh, my God, you know, what are we going to do here?!'. But I was with a social worker at the time, and we sort of talked through it with the patient and came up with a plan.

(Interview 6, p.7)

**Jenny** believes that team collaboration is vital. In their special unit, their very survival can depend on the mutual support they offer each other. The staff join together in a coalition to control the patients. They watch over each other and intervene to keep each other safe. She needs, and expects, the team to back her :

If I'm around on the ward people are aware that there is a potential problem. And I've got to the point where I don't even deal with R—any more. I expect staff to jump in. (Interview 9, p.12)

iii. The occupational therapy team is a safe refuge and a continuing source of support and supervision. There is a sense of sharing with others who really understand and we do not have to justify our professional identity.

**Susan** has regular supportive supervision with an occupational therapist, a relationship which she really values for the nurturing it offers as well as for general professional development. Supervision is her space to 'off-load', be herself, heal and learn. She feels she can be honest and does not have to justify her practice as she will not be judged negatively (which is unlike her experience in the wider team) :

The way that I've actually done that is to use my own supervision extremely well...there was something about having a lot of respect for this person I had supervision with...I guess it's about being able to be honest and not having to



play games. And there was something about acknowledging that part of the difficulty for me in terms of other peoples' criticism was that I wasn't sure about my own skills.....I think there is also a real skill in being honest about where your limitations are with your skills, and again that was something I used my supervision for...The supervision was very much about encouraging me to do it. It was very nurturing supervision... I grew in my confidence about how to use the supervision...helping me to redefine and re-clarify my skills because one of the things for me going into the community as an OT, as somebody who was working by themselves, isolated in a team, and as somebody who didn't have another OT community in ----, that was a pretty grim time.

(Interview 2, pp.7-9)

**Jane** regards her occupational therapy colleagues as an extra "family" - one that gives support. She is aware that she doesn't feel quite as close with her current team as she used to feel in her previous job, but she still identifies with and feels close to the other occupational therapists in particular. They are the people she would talk to about professional stresses and dilemmas and with whom she would share a more personal, friendly contact :

There was always somebody there...because it was a small team...everybody knew the clients very well indeed. So if I was off, one of my colleagues would know my clients, because we shared a lot more. But here it's not so easy because there's a lot of pressure on the work...But there's still a great deal of closeness...It is nice.

(Interview 5, p.3)

iv. Being part of the team helps us feel we are not alone - there is a place to turn to for advice, assistance and support.

**Jane** feels she needs the support of the team backing her as a safety net for when she gets stuck. The team also provides a safe haven - the company of a supportive group counteracts the intense isolation of being on the road all day by herself :

We've always got each other. I mean, if any of us has got a problem we can always go back to the office and say, 'Look at this' or 'Would you come out [with me] I'm really stuck here'.

(Interview 5, p.2)

**Paula** sees she has a lot of autonomy in her work and it can occasionally make her feel alone. She values her supervision and having team members at the end of a phone to give support when she needs it. For her it is of crucial importance simply to know that there is someone on whom she can fall back :

You always feel that it's left down to you, because we are so responsible for ourselves, we sort out our own workload...Yes we do have supervision, we have a case work consultant, and that's an excellent idea because you can



literally go to that person and say, 'Look I'm not happy about this, what can we do?' And you'll work it through together... That's another OT, who also has a caseload... But she's there and she's available, and even if you were to just get her on the phone, she is there, and it's so important to feel that 'Yes, I'm not alone in this, there is someone I can call in'.

(Interview 4, pp.7-8)

**Theme 4 : b) 'Good' colleagues, 'bad' colleagues : Levels of trust, respect and appreciation vary throughout each team. We collaborate with some people and are more tense or distant with others.**

i. 'Good' colleagues give support and the relationship is based on a closeness, mutual respect and trust.

**Karen**, expressing sentiments shared by all the physical hospital occupational therapists, considers multi-disciplinary teamwork to be of central importance. She allies herself firmly with the physiotherapists with whom she has a particularly close relationship and identification. They collaborate on the same patients' functional tasks whilst focusing on different aspects :

We're fortunate in sessions in that we would have joint sessions. So in the kitchen we would actually have both of us working together with the client. So the physio would be looking at the side stepping, the standing and posture, and we would be looking at actually doing the functional task in the kitchen.

(Interview 7, p.2)

All the **mental health occupational therapists** collaborate with other team members within therapy sessions (for instance, being co-leaders in group therapy). Such collaboration is experienced as fulfilling and as breaking down professional rivalry barriers :

Julie : I found a lot of really good colleagues. And at the moment I've been co-facilitating one group with a colleague who happens to be a nurse. And I have co-facilitated quite a lot of groups over the years.

(Interview 8 p.3)



- ii. 'Bad' colleagues are dismissive, disrespectful and rejecting. They do not appreciate our occupational therapy contribution.

**Cathy** struggles with some of her relationships, particularly with certain consultants who are not interested in, and do not appreciate, what she does :

I think, unfortunately, not all the people around that we work with, you know, hold us in that high esteem. You know, it varies from consultant... some think we're wonderful, some don't really know, know what we do and some really aren't very interested...and some people, despite how much you promote and everything, still don't know what we do.

(Interview 3, p.4)

**Julie** has struggled to be valued as a skilled and legitimate team member. She has found it personally painful not to be given that status and has had to fight to prove herself :

It got very personal. People would tell me, 'For my own good', that I shouldn't be doing the sort of things I was doing because that wasn't an OT's job...I started running relaxation groups and a stress management group, and I had it fed back to me by a community nurse that he had heard that people were very unhappy about it, and really I wasn't qualified to do that sort of work.

(Interview 8, p.3)

- iii. Degrees of collaboration and closeness - We pragmatically engaged in different sorts of team relationships as necessary.

**Peter** and **Anne**, in common with all the therapists, experience a range of different relationships at different levels :

- a) Overall, whatever the individual relationships, there is an imperative to work in a 'team' and formally liaise with others (attending meetings, writing reports etc.)
- b) In practice, the therapists have the closest and most personal relationships with the other occupational therapy staff in their departments. It is from this staff group that they gain support, supervision and a sense of professional identity. In terms of actual day to day clinical work they collaborate most closely with the occupational therapy helpers with whom they have a supervisory role.
- c) They also work closely with the physiotherapists, particularly as they need to negotiate the division of labour in their treatments for each patient.
- d) Their relationships with the nurses are variable : with some the relationship is closer and built on more mutual respect; with others they feel indifferent (experiencing the nurses as a nameless, amorphous group).
- e) They have the most distant relationships with the doctors, who are seen largely as authority figures. Personal contact (for instance, that which is achieved in nursing hand-overs which doctors do not attend) is limited. As Peter puts it, "Communication with doctors is very difficult." The distance between the



therapists and doctors is compounded as often communication is conducted through the nurses.

(Participant Observation 2,3)

**Theme 4 : c) Sibling rivalry : The team is also seen as a source of problems and conflict where we compete with others over territory and vie for recognition.**

- i. "Keep shouting out OT!" - It is a struggle to assert ourselves within the team, to be respected, to not be ignored and to make our voice heard.

**Cathy** struggles to assert herself and sometimes it feels as though she has to work up the courage to do so. She feels she has to "shout" to get others to give her some attention and respect. She dislikes being ignored. In particular, she feels in competition with the community psychiatric nurses who out-number her with the result that she can sometimes be forgotten :

I was in a meeting the other day, like a training session, and we were talking about referring to the CPN, you know, community teams referring to the CPN. And they kept saying, 'CPN, CPN', so in the end I had to say, 'Excuse me, but I work on a community mental health team and I'm an OT!' And these are colleagues that I work with! So, it does become, as I say, annoying to feel that you've got to justify and keep shouting out 'OT! We're OT!' (Interview 3, p.4)

**Mary** feels she has to assert herself with one particular consultant as he tries to manipulate and 'coerce' her into seeing certain clients. It is becoming easier now for her to resist him and assert her view as she is clearer about her role and she feels angry:

She was seen again in out-patients, and was told to come to see me again, and came back a second time. And basically I said, 'Well why are you here, we've been over this?' The first time I had said to the consultant, 'She doesn't want to be seen so fair enough.' The second time I said to this woman, 'Why have you come back?' And basically she didn't want to fall out with the doctor. And I said, 'Basically that that wasn't good enough reason.' It was wasting her time, if there was nothing I could offer, there was no point coming. I said to the consultant again, 'Look this lady has been back again, and I am not offering her another appointment.' I think in the past I would maybe have - not in this lady's case, because it was a bit more clear cut. But when it's a bit greyer that that I would maybe have said 'OK, I'll see them again'. I would



have been less clear I suppose about what I was offering. But now, if I feel there is nothing I can offer, I will not be coerced into doing it!  
(Interview 1, p.15)

ii. We are forced to compete when other team members try to usurp our role.

**Cathy** expresses the competition in terms of guarding her back. She feels she is in a battle for territory. Others are out to usurp her role, but equally she can encroach on others :

So, a little bit of antagonism sets up and it's sort of covering your own back, and saying, 'Well the physio hasn't passed any exams in mental health at all, what are they doing here?' What they have learnt is on the job, set aside, against, 'Well, if you teach me how to give injections then I can do the same as a CPN.  
(Interview 3, p.5)

**Jenny** feels she is constantly engaged in small role battles with other professionals, trying to defend or carve out territory. She feels tired of continuously having to fight the same battles. On the other hand, she sees team collaboration as the way forward. She fights for inter-disciplinary working and to break down barriers :

'Why do I have to do this again? I'm tired of doing this.' And you do, you know we're not always asking nurses why they're doing what they're doing... OTs are just as bad as nursing staff : 'Get out of here, and I do this and you don't do that'. And there are really big barriers to break down. They're enormous barriers... it feels very much like the collaborative working...are the way forward...that's the vision that I want to see. It is the smaller fights within it that get you down.  
(Interview 9, p.6)

**Julie** has had a battle on her hands with some colleagues to be accepted as a legitimate team member. In particular she has had to assert her right to read the medical/nursing notes, but this has been blocked by certain team members who are guarding their territory :

We did have problems with a consultant, who...was very autocratic and very old fashioned. I was having problems with access to patients' notes... and it was actually nurses who were blocking it...And then off and on there have been hiccups with access to nursing notes... One charge nurse decided that we couldn't see the notes because they were confidential. That really grieved me because we were losing out on an awful lot of information.  
(Interview 8, p.4)



iii. Sometimes jostling for status extends to vying for patients' approval and co-operation.

**Mary** struggles to value herself, as well as be valued by others, as a fully legitimate therapist. She was particularly upset when a neighbour of one of her clients denied she was a "proper therapist". This insult was made worse for Mary as the neighbour was a nurse and Mary had assumed there would be mutual respect :

Mary : And the nurse said to my client, 'I'm going to see a proper therapist.' - which I thought was quite funny!

Interviewer : Was it really funny or did it make your blood boil.

Mary : ...annoyance. I just felt bad for my client. And I just said, 'Well if that is what she think she ought to find out what her fellow professionals do.' That was how I left it. But it kind of amused me as well.

Interviewer : What that somehow you're not a 'proper therapist'?

Mary : Yeah [laughs]. But my client wasn't unduly distressed that she wasn't seeing a proper therapist, cause she just said how much benefit; how much help I had been. (Interview 1, pp.22-23)

**Karen** sees occupational therapists and physiotherapists as having some advantages over nurses. Patients co-operate with them, whereas the self same patients may be abusive to nurses :

Some patients will stand and do things for us but won't do it for the nurses, so obviously sometimes that's a bit of an issue... Whereas when they're with us, we're helping them to get home. 'And you have to do this to get home, and we need to get your legs stronger'. And the patients themselves are wanting to walk so they co-operate with us. But with the nurses, 'It's the end of the day, I'm tired. Why should I pull my covers up over me, you can do it.' Which then creates a bit of a problem because the nurses then say, 'Why will they do it for you and they don't do it for us?'  
(Interview 7, p.12)

**Theme 4 : d) Pressures, threats and imperatives - assaulted by the system :** The demands of the wider health care system are a constant pressure. We feel insecure in our jobs and powerless against



**management policy, whilst constraints on time and resources force continuous compromise.**

- i. Swamped by too many patients, tough deadlines and not enough time : The demands get intense.

**Paula** feels swamped by the numbers of people referred. She is constantly aware of waiting list numbers and the need to keep ploughing through her growing case load. She struggles with her time management, juggling her hours and trying to squeeze more in. She works hard to prioritise her cases and save time by not getting too involved :

I may get nine or ten referrals a day, and ...I don't get any extra time to do the referrals. It's part and parcel of my morning, and I literally need to look at them and decide there and then on the information that's been given...I'd love to phone up and find out more, but I just do not have the time. I may not get them until after half past eleven, and if I've got visits to go on..."

(Interview 4, p.4)

**Stephen** feels angry that he is referred so many patients with whom he cannot deal adequately or have the degree of involvement he would like. Instead he is forced into operating as if on an assembly line and he does the basic minimum with many of these 'bog-standard' referrals. This makes his work feel tedious, boring and routine :

It is frustrating. And it makes me angry sometimes, because there's things you want to do but you just can't fit them in. There's too many patients needing the bog standard things. (Interview 6, p. 4)

**Jenny** is under pressure from the Trust's management to produce reports to deadlines. She doesn't have enough hours in the day. She sees the demands on her as being so excessive they are a "farce" :

The way the Trust works we had to produce that information very quickly. And we found that, and I certainly wasn't alone, I can work anything up to a fourteen to fifteen hour day, and still do, because of the deadlines and the quality of work you have to produce. And the amount of it you have to produce! On top of all that we are supposed to carry a clinical load which is an absolute farce!

(Interview 9, p.2)



- ii. Ideals are compromised and involvements with others limited to accommodate constraints on time and resources.

**Peter** feels he has to compromise such professional values as being holistic given the realities of practical constraints of time and resources. He admits he sometimes does more than he 'should' but knows he can only play a small role - it is much more limited than he would like. For example, he could not offer anxiety management to a cardiac patient who would have benefited. He also knows the money is not available to make a significant difference to many patients' quality of life (e.g. rehousing the patient who lived in poverty which he discovered on the home visit). Peter also has to compromise where his values about quality of life conflict with a medical model whose priorities are different (e.g. as evidenced by tussles over discharge dates).

(Participant Observation 2)

**Paula** (along with most of the other therapists) prioritises her clients by limiting the numbers with whom she allows herself to get involved. [See theme 3 sub-section b)]

- iii. 'Watch your step! Cover your back!': The threat of litigation is always there and management is watching. It is imperative to keep patients/clients safe.

**Peter and Anne** (in common with all the physical occupational therapists) are constantly alert to the threat of litigation and the need to ensure the safety of their patients and practice. As part of prioritising their work load they have reduced their daily tasks to the minimum required for safety. They only see the patients they are required to see to cover themselves. They assess mainly personal activities of daily living with a focus on whether or not the patient has the ability to carry these activities out safely. They manage home visits with an eye to minimising physical risks on discharge. Finally, they write notes and reports on everything they do in order to cover themselves.

(Participant Observation 2,3)

**Stephen** is frustrated in his surgical role as he is required by management to rubber stamp doctors' discharge decisions. He considers this role has little value or meaning, except as a legal exercise, but he doesn't feel he has the professional autonomy to refuse. If he did, he would risk his job, as this task is what management values him for. He would also be told off by doctors :

Stephen : In general surgery we're often called in just to, 'somebody's going home this afternoon and we want to cover ourselves'. So you do a quick assessment, tell them they're fine...The person would go home anyway, so what's the point, apart from legally...it can be frustrating, but it's more that I could do without it. I'd rather they didn't ask to do it than sort of be involved at that level. If they ask me to do it, I'd rather give them a few days to actually do something with it.



Interviewer : So that you'd want to do it properly rather than rubber stamp?

Stephen : Yeah, so that my assessment had a meaning. At the end of it I was actually going to have a result of some sort rather than just saying yes or no.

Interviewer : So it's quite disempowering then when the consultants ask you to rubber stamp it. How do you handle that: Do you just rubber stamp it or what?

Stephen : Yeah. I don't think we've really got a choice in it. The pressure...they're pushing through I think three or four thousand patients in a quarter, that you've actually got to fit in with that. The organisation wouldn't accept, you know, an individual saying, 'Well, that's not how I think it should be done.' It is, it can be difficult, but you just do it because it means that the next patient can get in and have a bed....I think it is too difficult legally...Also, I've been told off a couple of times by consultants.

(Interview 6, p. 2-3)

iv. Feeling unsupported and insecure : The pressure is on to demonstrate value or else be made redundant.

**Cathy** fears for her job as an occupational therapist as she sees other professionals made redundant. She wonders if there is any point to continuing to battle at work if she is going to lose her job anyway. It is difficult for her not knowing what is going to happen :

I think we've got jobs for another year...but meanwhile...out of 14 CPNs, they're going to probably be making two redundant...next year it will be likely the OTs...It makes life very difficult, not knowing whether on one hand to fight the battle, or not...you think, 'Well what's the point if there's no job anyway?'

(Interview 3, p.4)

**Stephen** feels frustrated and unable to carry out what he sees is the occupational therapy role, as management require him to perform only a small part of his functions : it is only by enabling quick discharges, that he will keep his job. He feels management does not value his real potential but he feels forced to go along their agenda :

Stephen : The organisation mainly values the individual part of the role : our ability to assess and provide...that's the small part that our high up management... that's why, maybe, they keep OTs. But within the ward setting, I feel that the whole role is valued by most of the staff which I think you really just need to live within that and let the management get on with it."

Interviewer : "It sounds like the management's view, your view and perhaps the ward's view is actually completely different(?)"



Stephen : ...just the way we are treated from above. But the Chief Executive said that there would be no jobs at risk for people who are involved in discharge planning, discharge facilitating. So I think that typifies what the value, what the important part is for them. It's not the actual rehabilitation.  
(Interview 6, p. 4)

v. Feeling powerless in the wake of management action and policies - But they can be fought and some control taken back.

**Paula** confronts those in authority on behalf of her clients and even (to her shame) engages in shouting matches with them. But in the end she knows they hold the purse strings; financial constraints are always present. Whilst she has the professional autonomy to make choices about allocating resources, she cannot argue for more money. She is always conscious of the realities of the financial constraints :

When you're actually in that client's home, doing that assessment, on that visit, you have all...the restraints in the back of your mind...financial restraint, because if, if I was asking for anything beyond a straightforward ramp, we would have to go to the Council for a grant for a disabled facilities grant, and they have extremely strict criteria...If you feel strongly enough about a client's situation, you can argue...because...they do really respect the OT's assessment...I've had shouting matches, totally unprofessional shouting matches down the phone with the Chief Environmental Health Officer that does grants... I'm ashamed to say this, but we literally came to blows.  
(Interview 4, pp.9-10)

**Susan** copes with external demands and dictums on her by pretending to go along with them. When forbidden to enter into counselling with sexually abused clients, she elects to engage in covert practice and carries on, with team members colluding with and supporting her decision :

The guidelines are really hazy. There's something about, you know, if the person comes initially presenting with sexual abuse, then I'm not supposed to do it. And basically what I've got is permission from my District OT that OTs can do that work if they've got the proven skills, so I still do it.  
(Interview 2, pp.20-21)



**Theme 4 : e) Ideal images versus tough reality : It is hard to hold on to past ideals and images of the team when the team feels divisive, destructive and damaging.**

- i. Tread carefully in this team full of power struggles - the battle can cause damage.

**Jenny** experiences many battles with staff - often in the context of defending either her staff (from macho-management) or her patients (from incompetent staff). She sees the staff team as potentially very difficult, possibly because of the closed environment. She believes that one of her main values is being able to do battle, but she also knows that sometimes the battles can backfire. She is particularly wary that more challenging staff members may take revenge :

It's a very difficult staff group. They are quite challenging, quite a lot of them...sometimes you feel like walking on egg shells because if you upset somebody they can actually interrupt your treatment...You have a fall out with the staff nurse...you go up the next day and you might need an escort for a patient to come down to the kitchen, and suddenly it's, 'Umm, no, no, I'm sorry there isn't anyone'. So you have to be careful.

(Interview 9, p.4)

- ii. It is important to be vigilant about team problems and to struggle with finding ways to minimise the damage. Sometimes it is a 'no win' situation.

**Julie** feels she has to be patient and that problems do not sort themselves out overnight. But she struggles to find the best way through. She experiences the dilemma of knowing that often solutions to team conflict also contain costs. For instance, nursing placements within Occupational Therapy help raise mutual awareness of their respective roles. On occasion, however, the placements have been so destructive they have had to be cancelled which has reduced stress but problems remain.

If you don't ripple the water too badly it kind of dies down and sorts itself out over a period of time if you can be patient...We used to get student nurses on placement in the department. We no longer do and we actually stopped those placements because we had a spate of very destructive placements that were sapping staff energy. People were actively sabotaging groups. And we were getting no backup from the college. Basically they were saying, 'Oh well, that's your problem.' But 'It's not our problem, it's your student nurses' problem. Come and take them away from us!'. Not having student nurses has reduced stress, but it has also meant that a lot of students don't get the opportunity to really learn what we're about. Because I guess for each student nurse who nearly drove us to distraction, there are people now who are really



close colleagues, who really know what we do.  
(Interview 8, p.5)

iii. Feeling betrayed by the realities of practice.

**Mary** has recently experienced a sudden ‘tear’ in her feeling of connectedness to others in the team; she has come to realise the support she had previously taken for granted simply was not there. She had thought the team members would protect each other in the face of abusive, damaging clients. Now she can no longer trust other members not to set her up and put her deliberately in the firing line. She feels more alone as she has called for help and it is not there :

Mary : I mean it’s funny isn’t it, people tell you something at the time and you think, ‘Oh no, you’re over-reacting.’ But when you’ve been through that, you can see why they’ve said it. So I think it’s the team - not the team versus the consultant, but definitely coming from different angles...

Interviewer : And you’ve actually been burned now, or in a sense you’ve lost some trust?

Mary : ...Yes...I think it's quite sad in a lot of ways, because instead of everybody working together, I suppose it’s always been there, but not as noticeable.

(Interview 1, p.15)



## SUMMARY of theme 4

The relationship with the multi-disciplinary team plays a powerful role in the therapist's life world. The therapists have a general sense of the importance of 'the team' (as one entity) as it offers an identity, meaning and a structure to the working day. It is also a source of mutual respect and esteem. At the same time the therapists engage in multiple relationships at different levels - both close and distant - with individual team members.

In general, the team is viewed as an alternative 'family', with all the positive and negative dynamics that implies. The team is both a safe haven of mutually supportive relationships and a battleground of conflict and competition.

Viewed as a safe haven, the team offers collaboration and a chance to share in decision making in alliance with, or in coalition against, the patients. The team also offers a refuge where the therapists can heal and develop away from daily stresses.

However, the team-as-battleground reveals power struggles where the therapists engage in constant battles to be valued and respected, and to carve out territory. They live with intense pressures : too many patients, not enough time, and always the need to prove their worth in the face of threats of litigation and redundancy. The therapists learn to put aside idealised images of the team as they experience the painful reality that, as in civil war, people can get hurt.



## 4.2.5 SUMMARY OF SUB-THEMES

Theme 1 :

### **WHO AM I? THE FRAUGHT SEARCH FOR AN OCCUPATIONAL THERAPY IDENTITY**

- a) Valuing and rejecting occupational therapy : We're enthusiastic about occupational therapy but we want a different identity.
  - i. Occupational therapy (OT) is valued, and believed in, but it is not enough.
  - ii. Having a diminished sense of being an occupational therapist results in embracing other roles. Occupational therapy is the passport to be other things.
  
- b) Struggling to define boundaries : The conflicting meanings of occupational therapy are confusing.
  - i. Searching for an identity to become a 'proper occupational therapist'
  - ii. Past versus Present - shifting images of occupational therapy
  
- c) Compromising on holism : Patients should be viewed as 'people', but the practical realities of the work context make it difficult to avoid categories and labels.
  - i. Patients/clients need to be seen as individuals with their unique needs and particular personal/social histories.
  - ii. Being 'holistic' means different things.
  - iii. Tensions are experienced between occupational therapy values and the demands of the system.
  - iv. Medical diagnosis should be resisted so as not to stereotype patients/clients.
  - v. Contradictory use of labels? Categorising within a holistic approach.
  
- d) Constructing a new identity in a changing world : We feel the need to demarcate a territory and stake a claim for a new, more prestigious identity
  - i. Carving out specialist territory in search for more status.
  - ii. Split identity : evolving multiple selves
  - iii. A new occupational therapy? - Re-defining the boundaries



Theme 2 :

## **THE MISSION TO MAKE A DIFFERENCE : ENACTING THE THERAPIST'S CRAFT**

a) Believing in the mission : Occupational therapy has an important value and purpose.

- i. Occupational therapy is a worthwhile and meaningful occupation.
- ii. The work evokes passionate commitment, but sometimes motivation slips.

b) Enabling change - the struggle and thrill of transformation : The therapy process is a challenge, but it feels worthwhile when positive changes take place.

- i. Seeing progression take place over the course of treatment is fascinating, exciting and rewarding.
- ii. Playing an active part in the transformation of patients/clients is satisfying. Seeing change gives meaning to therapy.
- iii. Our mission is to save patients/clients and offer them a better life. The patients'/clients' achievements are ours.

c) Striving to feel effective, valued and appreciated : Changes observed in patients/clients are associated with feeling competent and effective. When patients/clients are stuck, it is frustrating and we question our skills.

- i. It feels good and satisfying to enable change, though how change can be brought about varies.
- ii. Receiving positive feedback that therapy interventions are valuable and worthwhile is 'brilliant'. When someone is helped to change the appreciation and thanks received is encouraging.
- iii. Positive feedback helps personal and professional development.
- iv. We despair when patients/clients are 'being horrible' and don't respond.

d) Theme 2 : d) Strategic planning or intuitive magic? : The approach in therapy is carefully planned but sometimes solutions come intuitively and spontaneously.

- i. Patients/clients need to be 'handled' to find the best way to engage them co-operatively in treatment.
- ii. The therapeutic process needs to be carefully planned. Clinical skills and knowledge about grading and adapting our role are used continually within the treatment environment.
- iii. It is hard to describe the healing process - the 'magic' of therapy. Somehow we each offer something special.
- iv. Problem-solving is often intuitive and unplanned. It evolves within the therapeutic relationship, through trial and error, whilst being alert to cues and possibilities.



e) Practical problem solving - envisioning the past, present, future : Focusing on tactics to overcome functional problems.

- i. We weave stories about our patients and clients. We look at their current functioning, and imagine how they were in the past and their potential for the future.
- ii. Novel strategies need to be found to help patients/clients move on. It is a challenge which utilises all our skills, but it is worth it as moments of successful, creative problem-solving are good.
- iii. We need to work with patients/clients through the problems in sequence. It takes time and a systematic approach.

f) Being and doing through activity : Striving to capture the creative moment and enjoy the mutual participation.

- i. Our craft involves using activities in different ways and getting the patients/clients involved in 'doing'.
- ii. Participating with patients/clients in the activity treatment process is enjoyable and exercises therapeutic skills.
- iii. 'Getting a kick' - Special connections are made in the 'doing' process towards enabling change.



Theme 3 :

### **NEGOTIATING THE BOUNDARIES : THE CARING-POWER RELATIONSHIP**

a) Being caring, sharing and empowering : We want to give of ourselves and share our professional skills and knowledge.

- i. 'Caring' means feeling warmly concerned about patients/clients and wanting to help. It means sharing in the patients'/clients' suffering and being there to lend support and comfort.
- ii. Seeking to connect with, and gain from, patients/clients through working together : Having a mutual relationship is important.
- iii. It is important to be non-judgemental and accepting, and to value patients/clients. Patients/clients need to be enabled to be more confident and independent.

b) Intense giving or pragmatic detachment? : Negotiating personal and professional boundaries of intense involvement versus maintaining a professional distance.

- i. Relationships with patients/clients can be superficial or intense. Sometimes the relationship is transient, and forgotten quite quickly; at other times emotions are involved as the relationship develops over a longer period.
- ii. Striving to get close whilst not too emotionally involved : It's a struggle to define personal versus professional boundaries, and negotiate levels of intimacy. Personal contact makes work satisfying and rewarding, but it is also a source of stress and pain.

c) Trading control for collaboration : Relationships are best when egalitarian.

- i. Patients/clients should actively participate and collaborate in treatment.
- ii. Patients/clients need to be empowered.

d) Being sucked dry : Patients feel like needy, dependent children when they demand nurturing or force authoritarian responses.

- i. It is hard to resist transferences. As 'parents' we feel guilty about not giving enough or feeling angry. We also experience a tension as we do not want to give too much as that works against the aim of enabling independence.
- ii. . 'If only they would comply with the logic of the treatment!'. Sometimes the patients/clients play games, resisting our direction and expert advice as they challenge our authority

e) The battle for control - the patient as adversary : It's a battle to control patients/clients.



- i. It can be a battle to control angry feelings and not get aggressive. In the end, the patients/clients cannot be coerced and we must accept their decisions.
- ii. Feeling manipulated, set-up, damaged and powerless

f) 'Creepy', threatening patients - keeping a safe distance : We manoeuvre to avoid abuse.

- i. The threat of abuse is always there, waiting, around the corner.
- ii. Dealing with patients who have violent sexual histories is threatening. As women, somehow the threat of being sexually assaulted or 'invaded' is more frightening and distressing than the threat of straightforward physical violence.



Theme 4 :

## **SAFE HAVEN OR BATTLEGROUND? COLLABORATION AND CONFLICT WITHIN THE TEAM**

a) Caring for each other : The team is a source of identity and support. It feels good to share and co-operate in team decision making.

- i. The multi-disciplinary team, means sharing in decisions and jointly negotiating treatment plans.
- ii. It is important to collaborate on treatment planning as other professionals can inspire confidence and ideas. It is a relief to share with others. Also, team collaboration means safe practice, even survival.
- iii. The occupational therapy team is a safe refuge and a continuing source of support and supervision. There is a sense of sharing with others who really understand and we do not have to justify our professional identity.
- iv. Being part of the team helps us feel we are not alone - there is a place to turn to for advice, assistance and support.

b) 'Good' colleagues, 'bad' colleagues : Levels of trust, respect and appreciation vary throughout each team. We collaborate with some people and are more tense or distant with others.

- i. 'Good' colleagues give support and the relationship is based on a closeness, mutual respect and trust.
- ii. 'Bad' colleagues are dismissive, disrespectful and rejecting. They do not appreciate our occupational therapy contribution.
- iii. Degrees of collaboration and closeness - We pragmatically engaged in different sorts of team relationships as necessary.

c) Sibling rivalry : The team a source of problems and conflict where we compete with others over territory and vie for recognition.

- i. "Keep shouting out OT!" - It is a struggle to assert ourselves within the team, to be respected, to not be ignored and to make our voice heard.
- ii. We are forced to compete when other team members try to usurp our role.
- iii. Sometimes jostling for status extends to vying for patients' approval and co-operation.

d) Threats and imperatives - assaulted by the system : The demands of the wider health care system are a constant pressure.

- i. Swamped by too many patients, tough deadlines and not enough time - the demands get intense.
- ii. Ideals are compromised and relationships limited to accommodate constraints on time and resources.
- iii. 'Watch your step! Cover your back!' : The threat of litigation is always there and management is watching. It is imperative to keep patients/clients safe.



- iv. Feeling unsupported and insecure : The pressure is on to demonstrate value or else be made redundant.
  - v. Powerless in the wake of management action and policies - but they can be fought and some control taken back.
- e) Ideal images versus tough reality : It is hard to hold on to past ideals and images of the team when the team feels divisive, destructive and damaging.
- i. Tread carefully in this team full of power struggles - battles end in damage.
  - ii. It is important to be vigilant about team problems and to struggle with finding ways to minimise damage. Sometimes it is a 'no win' situation.
  - iii. Feeling betrayed by the realities of practice



### 4.3 REFLEXIVE ANALYSIS

In this section, I attempt a reflexive analysis which aims to evaluate how subjective and inter-subjective elements have impinged on the research process, including both data collection and analysis.

Two basic assumptions underlie this reflexive analysis :

- 1) The researcher holds a central position in the construction of knowledge. My research has been fundamentally determined by my assumptions and interpretations. However much I have attempted to suspend judgements, I come from a particular perspective and, it seems to me, this personal, subjective dimension has always been present. Thus, this reflexive analysis acknowledges that my emotions, understandings and values have been continually engaged, however non-judgemental I have tried to be.
- 2) All research takes place within a social context : another researcher, in a different relationship and context, will unfold a different story. This reflexive analysis acknowledges the broader dynamics of the relationship between myself and my participants and how this was negotiated in a particular time and place.

In order to begin to capture the complexity of how subjective/inter-subjective elements have intertwined with my data collection and analysis, I offer a range of illustrations of taken from my research and reflect on their implications. I attempt an evaluation of three interlinked aspects, namely :

- my chosen methods of research (methodological reflexivity)
- my subjective responses (personal reflexivity);
- the dynamics of the relationship between myself and my participants (social reflexivity).



**Methodological Reflexivity**

Methodological reflexivity involves researchers becoming critically aware of their impact on research decisions throughout all stages of research design, data collection and analysis.

Even before the research begins, the researcher’s identity comes into play, for the selection of topic to study will be an expression of his/her personal concerns. This was very relevant in my case. In common with many occupational therapists, I have been preoccupied with trying to identify our role and spot differences between our experiences (for instance between physical and mental health occupational therapists).

Once the research starts, it is important to continue to examine impact of particular research interests or investments. I had started the research with a particular interest (dating back from my undergraduate research) in therapists’ views of their patients/clients. I wanted my research to demonstrate the extent therapists labelled, stereotyped and diagnosed patients, contrary to the rhetoric. This interest impacted on my data collection. Far from being non-directive in the interviews as intended, I found myself asking specific questions such as, ‘Who are your favourite patients?’ or ‘What do you mean by 'social need' cases?’.

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As part of the process of evaluating how my preconceptions, prejudices, expectations and attitudes might influence the data collected, I examined what the impact of my being an occupational therapist interviewing other occupational therapists might be. My insider status was undoubtedly going to be significant given the biases and assumptions that stem from it.

In some ways, being an insider was a comfortable and easy role to adopt. I was able to dress and behave as 'me'. The research participants and I have had a similar professional socialisation and background. We shared the same language and jargon, even the same jokes. I could identify with them, for example, when they spoke of their challenging patients or problematic team relationships. Through understanding my own satisfactions, dilemmas and tensions about being an occupational therapist, I could better understand theirs. My previous knowledge gave me insights which outsiders might not have picked up.

On the other hand, I needed to guard against assuming that we shared the same language and meanings and saw the job in the same way. If I made such assumptions, I was in danger of missing points of difference. This came home forcefully to me when I started my first participant observation in the field. I started with the assumption (based on my mental health experience) that as therapists we have a fair amount of professional autonomy and that team relationships are reasonably egalitarian. It came as quite a surprise to me to find out how hierarchical some practice could be. Jane, for example, found that no less than a quarter of all her referrals were inappropriate - but she still carried on seeing these clients. When I asked why, the answer came back, 'because the doctor has requested it, it's prescribed, so I must do it'. That was the first time I realised how major some of the differences in our professional experience



might be. Had I not reflected on (and recorded) my assumptions, I might have missed seeing that professional responsibility and autonomy meant different things for each of us. My subsequent analysis picked up the significance of occupational therapists having both *individual* and *shared* meanings.

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In addition to my own assumptions and experience, I needed to take on board my participants' expectations. I was particularly concerned about the possible impact on my participants of my 'reputation' and perceived status as an academic writer and 'authority'. I believe this did have some influence on some of them. Both Susan and Cathy had attended a lecture I had given, though I do not know how much this shaped their reactions to me. Julie at one point made a strong argument in support of the model of human occupation. Did she know this was my special interest area and therefore fed me the 'line'? Did Peter, relatively fresh out of college, feel inhibited at having me (one of his textbook authors) observe him? He was certainly anxious and conscious of being observed, but was that mainly about him, rather than anything about me? By the end of the week I suspected it was more about him, as he seemed nervous with everyone and he never raised the topic of my background. For the other therapists I am conscious of a continuing gap in my understanding. I do not know if they knew of me and I did not like to ask in case I created extra inhibitions.

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As my research progressed, I came to realise that I had a considerable investment in my research findings. I wanted the therapists to reveal themselves as I had envisaged



them. I had a specific investment in the mental health occupational therapists and I wanted them to be clear and confident about their role. The first three interviews with some of the mental health therapists therefore came as a rude awakening. They seemed anything but clear and confident. My initial response was to feel irritated with them and I became preoccupied in the interviews with getting them to identify their role. However, as the research evolved, my investment in the therapists' responses lessened. I had fewer expectations and so felt more tolerant. My irritation with my participants eased, I was better able to see their strengths and confidence. All this was then reflected in the analysis. Whereas at the start the individual analyses centred on confused identity, my later analysis increasingly took on board the therapists' belief in themselves and their enjoyment of their craft.

Another aspect of having invested too heavily in the research outcome was that I sometimes experienced uncomfortable tensions between being my two roles as researcher and as therapist. The researcher in me wanted to probe and challenge the therapists. The therapist in me wanted to 'save their face'; I wanted them to perform well and say professionally sound things. This came home to me forcefully when one participant admitted to treating sexually abused clients - which was against unit policy. The researcher in me was quietly excited by this disclosure of covert practice; the therapist in me was sympathetic, concerned and appalled. Mostly I did not want to hear about it and I wanted to tell her to protect herself and not publicly admit such things.

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When we recognise how researchers' assumptions and experience can influence data collection and analysis, a number of things follow. Two points strike me as particularly relevant :

- 1) Firstly, I had avoided conducting a significant portion of the literature review until after my data collection and analysis. However, I still had to concentrate on 'bracketing', to eliminate presuppositions and set aside theory so as to permit the lived experience of the person to be revealed. This was easier said than done. Although I had not conducted a formal search, I was all too aware of key occupational therapy issues, theories and research. I was prepared for themes to emerge around the search for an occupational therapy identity and struggles regarding holism and team relationships, and that is what I got. Might the therapists have focused on other areas (for instance, more on their craft) had I not somehow led them in this direction?
  
- 2) The second relevant point relates to my experience as a therapist. In particular I started the research with a respectable level of 'interviewing' skills already in place. I was practised at being relatively non-directive and appearing reasonably warm and relaxed. I was trained to enable personal disclosure. All these were useful skills. But, interestingly, my experience also blocked me to a degree. For one thing, I assumed I was 'empathetic' and that I wouldn't have to work so much on this. I was wrong. Over the course of the research, I learned how phenomenology requires a different sort of empathy - one involving high degrees of emotional identification and therefore time-consuming. It was when I returned to Mary, after a gap of two years, to 're-do' the analysis of my first interview that the gulf between



therapy and phenomenology as interviewing techniques and analytical approaches was brought home to me.

Through all this reflection I learned an important lesson about phenomenological research. I realised it could only be as good as the researcher's experience and the techniques applied. This, of course, has implications for my research, as it suggests that my latter interviews were probably 'better'. Certainly I feel they yielded richer phenomenological insights. I also learned that my own development in this area will never stay still. I think it is likely that with more experience I would do the interviews and analysis differently. Can one ever 'master' the phenomenological approach?

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In the latter stages of research, reflexivity has involved me recognising that I have been a conscious agent who has made choices and interpretations. Given this, it seemed necessary for me to evaluate my contribution to the analysis and theoretical conceptualisations. One point is clear : throughout the analysis stage I used my own understandings and experiences of being an occupational therapist. When I was evolving the generic themes that sought to capture commonalities in the therapists' life worlds, I would ask myself if my findings also reflected my experience. Moreover, it was my experience which led me to realise my analysis was somehow incomplete.

After the first stage of generic analysis, I had identified a number of themes relating to the therapists' identity, role and relationships. What was missing was something about the pleasures and satisfactions of actually *doing* occupational therapy - what I later called 'enacting the craft'.



In final stages of the research, I became increasingly aware of the fact that I was consciously and strategically selecting material to present. The thesis was ultimately my construction. Several factors influenced the selection of material, not least of which was my attempt to write a powerful, punchy story. Thus, the quotes selected were the more strongly worded, if less typical, ones. I selected material conscious that the thesis was going to be available in the public area and would be open to scrutiny by both the academic and occupational therapy communities. Clearly this provided some constraints and resulted in some censoring of the material (particularly of my personal reactions).

## **Personal Reflexivity**

Personal reflexivity involves consciously exploring one's own behaviour, emotions and responses in order to gain insight into those of others. By becoming aware of our own emotions we may be able to better identify the reactions of others and so have a greater degree of empathy. The fact that we share emotional responses means understanding another's experience is easier.

In my research, there were numerous occasions when, through probing my own reactions, I gained new understandings and deeper insight. Four illustrations of the role personal reflexivity played in my research are detailed below :



- 1) To begin with, it is important to recognise that I identified particularly strongly with all the mental health therapists. I felt I could empathise with their tensions and struggles. For example, I identified with the difficulties Mary was experiencing with her manipulative, unchanging client. I, too, had had a client who sounded very similar. I, too, had loosened my boundaries and defences to no avail. I, too, had had a sense of hurt, betrayal and failure. Because I had felt these feelings, I was all the more attuned to picking them up in Mary.
  
- 2) On one occasion during my observation of Anne, I observed her work with a patient who was suffering from the final stages of lung cancer. Although I was supposed only to observe, I found I could not stop myself becoming involved, asking the patient questions and even intervening at a practical level. When I reflected on my behaviour, I understood it was my active need to be involved - to do something. I also recognised my own sensitivity as an asthmatic, witnessing someone with breathing problems dying of a lung disease. Once I recognised this, I could then see that the occupational therapist was experiencing similar identifications with other patients. Previously I had interpreted Anne as being involved with fairly superficial, 'irrelevant' tasks; now I could see these tasks had a meaning for her : they were as much for her as for the patient. By examining my own responses I could better understand hers.
  
- 3) Another example from the participant observation occurred when I found myself feeling angry with the therapist concerned. My anger was stopping me from listening and empathising and I needed to examine what was happening. I was feeling angry on behalf of a patient who needed to stay longer in hospital to complete a range of crucial assessments. The patient's therapist, however, was



unable to challenge the doctors who were intent on discharging the patient. On reflection, I interpreted my anger as mirroring the therapist's anger at herself. She regularly put herself down for not communicating more assertively with doctors. On delving deeper, I located what appeared to be the real source of both of our angers : the hierarchical system that invested the doctor with such power. By reflecting on our shared emotional responses I was led to locate the context which seemed to prompt those responses and to recognise its importance in shaping how therapists experience their work.

- 4) A final example of my how my own experience gave me insight into the other therapists' experience was the moment I entered the forensic unit. I had a powerful reaction as I walked through the security system, with its locked doors and scrutiny by guards, to be handed the set of keys with the attached alarm. My general level of stimulation and excitement was balanced by anxiety about going into this forensic environment. But my strongest feeling was one of oppression. This gave me a sharp insight into Jenny's sense of oppression and tension, part and parcel of her daily experience. I could well understand her sense of freedom when she escaped on a shopping trip with a client and her sense of relief as she left the unit at the end of the day.

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At a psychodynamic level, researchers can also explore their own unconscious needs, fantasies or transferences the better to understand participants' responses. Examples from my research of how reflexive analysis can be taken to this deeper, unconscious level emerged during several of the interviews I conducted. I found that when I asked



questions and probed participants' feelings, the therapist in me somehow got activated. On several occasions I had this strange sense that the individual therapists I was interviewing were my clients. They would be talking about treating damaged, vulnerable people, and I would start to see them in the same way (particularly when they were tearful - a not uncommon occurrence). On a couple of other occasions, I was unsettled when I recognised that at times I also felt distant - not my usual 'empathetic' self. On reflection, I eventually realised my distance was in fact a defence - a manoeuvre I have used as a therapist to cope in my clinical practice and which seems to reach back far into my childhood. Reflecting on how these transferences might have impacted on relations with my participants, I realised that adopting a 'sensitive listening therapist mode' or a 'distant, professional mode' may well have prompted 'tearful-client' responses in my participants.

Another example of exploring unconscious dynamics occurred during my participant observation with Jane. During this, I found myself making the interpretation that she was 'in love' with her car. Somehow that beautiful, green, shiny car was symbolic of something much deeper. I came to this interpretation by combining general observation of Jane's behaviour with my own sense of being in the car. At a conscious level, it was clear she enjoyed her car. She visibly got a 'buzz' from it, often commenting on how nice it was, how well it drove, and so forth. The fact that her appearance always seemed to colour-co-ordinate with the car reinforced the impression of her general pride in its appearance. At a deeper level I could see it acted as an extension of herself as a community occupational therapist. The boot was filled with all manner of the usual bits of equipment and it was very much part of her work routine to go and rummage in the boot, collecting or depositing items during each visit. As the week with Jane progressed I started to pick up more subtle messages about



what that car meant to her. I began to feel a sense of relief as we returned to the car after a visit. Somehow one was back in a 'safe' place. In that car we could think, laugh, be natural and generally 'off-load'. It became clear that that car represented security, a constant environment in an otherwise fragmented work world that involved a plethora of clients' homes. The car was Jane's 'space'. It is also her assertion of independence and autonomy - the place where she could be who she wanted to be. This point was reinforced when Jane admitted she had bought the car in the face of fierce resistance and criticism from her father.

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One of the practical implications of personal reflexivity is that researchers need to be constantly be aware of, and to record, their own feelings, thoughts and responses. However, it is not easy to do this in practice without becoming trapped into excessive navel gazing. I have found that being preoccupied by one's own emotions and experiences can skew findings in unfortunate directions. On occasion, especially during the participant observations, I became over-attentive to my own feelings, at the expense of hearing the participant's voice. Sometimes I would have to work quite hard to guard against engaging too much with my personal responses and keep focused on participants.

Having acknowledged this, there were insights which directly emerged out of being preoccupied with my own personal responses. One came when I wore the occupational therapy uniform during my week in the physical hospital. As I donned the uniform on the first morning, I had a moment of panic. The uniform engendered in me a number of mixed emotions. My reaction was so powerful I felt I had to explore



it. So before I went up to meet the therapists I sat down to record my reflections in writing. I returned to them several times over the week. The following excerpt from my diary gives a flavour of what I was going through and how I came to a deeper understanding of the experience of wearing a uniform :

*My own relationship to myself as an OT seems to have taken on a new dimension - not least because I feel ambivalent about wearing this uniform! I feel as though I am rather play acting a role - playing 'dressing up'. That's the funny side. Also, much to my surprise, I find some of my abhorrence of the uniform has diminished as it is reasonably inoffensive (unlike the way they used to be when they were made out of crimpolene!). Having said that I can also still feel my dislike of uniforms in general and I do feel uncomfortable wearing one. I am also aware of how quite a lot of (bad) memories have been evoked of my student days of being in hospital, in uniform. I find that part of me is conscious that I am wearing incorrect shoes, my hair is not quite 'acceptable', I am wearing bangles...in my student days I would have been expelled for all this. But I am not going to compromise any further at this point. I have filed my nails and put my hair in a plait and I am sure (I certainly hope!) that is more than acceptable in this day and age. I would be interested to see how much easier with the uniform I will feel as the week rolls on...*

*Writing later on in the week, I have had further thoughts about wearing this uniform : 1) the uniform is quite nice in that it offers me a sense of being an insider; being accepted and legitimate somehow. It particularly hit me when a doctor entered into a fairly deep personal/professional conversation with Peter and had automatically included me. Clearly the uniform acts as a sort of passport - and I quite liked the inclusion. This feeling of belonging would not have happened in psychiatry mufti. 2) The negative side of my experience of wearing the uniform I find is that I dislike the anonymity, the lack of individuality. I find myself wanting to have the staff (particularly Peter) I am working with see me in my usual wear and thus how I 'normally' am. Somehow the uniform takes all that away. On the other hand, this anonymity is helpful/right for the role I am playing - the more anonymous I am the better. So it is okay. 3) Then there is the feeling of power which I find myself feeling both negative and positive about. People are passing me in the corridor and giving me what I interpret are 'respectful nods'. This uniform clearly has some power and I am feeling it too. I have always known I feel negative about this kind of thing - but my positive response comes rather as a surprise to me. I'm kind of enjoying the power and status! . 4) I notice in the changing rooms at the beginning and end of each day how naturally staff wear and take on/ off their uniforms in front of each other. It is part of the routine. It has a practical purpose. But I also sense that they too like the identity/status/belonging that it affords them. Also, they care about the cleanliness etc. of the uniform - it is about how they present themselves.*



My reflections on wearing a uniform therefore helped me understand something of the therapists' own experience of wearing one. I would never have gleaned this through simple observation. And the therapists themselves would have been unlikely to tell me about it themselves, since, for them, wearing a uniform is such a routine, unreflective procedure.

## **Social Reflexivity**

Social reflexivity focuses on the social context of the research and how research findings may be a product of the dynamics of the researcher-researched relationship. In particular, social reflexivity recognises that another researcher (or the same one at another time) is likely to unfold a different 'story'. It therefore becomes necessary to explore what contributes to the production of the story given.

In phenomenological terms, the focus is on the co-constitution of meanings of a person's life world; it is recognised that the description of the life world by the participant is achieved through conversation/interaction with the researcher. For social constructionists, greater emphasis is placed on language, discourse, the impact of the ideological context and on how findings are negotiated between researcher and researched.

An example of social reflexivity in my research arose when I discovered that one of my research participants would be a male therapist. My previous experience, backed by a review of the literature, suggested that in interviews men are less able to speak about



their feelings compared with women. Carrying this 'baggage' into the interview, I was not surprised when my participant actually said something to the effect that he 'didn't have feelings'. In response, I found myself feeling irritated with what I saw as a cold, mechanical approach, one that was inappropriate in a therapist. I found myself being uncharacteristically challenging with him. I pushed him to get an emotional response. Then, towards the end of the interview, he gave it to me. He spoke, quite painfully, about how difficult it was to handle certain emotions and how he had to cut off from them at work. I then felt guilty for having been so insensitive and forcing such disclosures. Reflecting on this, I wondered about the extent to which I set all that up with my initial assumptions. To what extent had he produced behaviours, both the mechanical and emotional, because I was inviting them? I needed to be sure that what I received from my informant was not simply a product of my behaviour (despite my best intentions to be both non-directive and non-judgmental). Equally, to what extent did his behaviour provoke my irritable responses?

Having engaged in reflexive analysis, I concluded that I had clearly influenced my informant. I came to understand that the multiple, contradictory ideologies around in our culture also had a considerable influence and that emotions reflect our ideologies. For one thing, I suspect my informant had internalised the same messages I had about 'acceptable' gender behaviour. But I now saw that he would have been exposed to other ideologies - for instance, how as professionals we should be empathetic/emotional as well as professional and in control of our feelings. My negative reactions probably reflected the society within which the occupational therapist practised and had to struggle. In this way, my reflections about my own assumptions, society's ideas and my informant's inconsistent presentation became part of the research data I needed to take note of and analyse.



\* \* \* \* \*

The ideological context has been an ever-present, but often unacknowledged, dimension in my research. It is clear that I have come into the research with my own ideological baggage, particularly with regard to occupational therapy in the health care context and how it should be practised. To some extent, I have shared beliefs with the other occupational therapists (for instance in striving towards holistic practice) and this is not surprising in view of the fact we are all products of a professional socialisation process. But differences have also become apparent. My research revealed divergences in thinking and understanding between the mental health, physical and community therapists. This has impacted on my relationships with the participants and my understandings of their life worlds.

Throughout the research I identified particularly strongly with the mental health therapists. We ‘spoke the same language’. The physical therapists were more ‘alien’ and in some ways that made them more interesting. Perhaps, too, I respected them more, admiring their skills and respecting how hard they worked. Might I have taken the mental health occupational therapists too much for granted?

At a different level, I cannot ignore my negative responses to the physical occupational therapists. I often found myself feeling critical and, however much I fought it, I judged their practice. I reacted negatively to a range of attitudes. I disliked their undue concentration on personal activities of daily living, where their practice seemed uncritical, unreflective, atheoretical and reductionist. They seemed to me to lack a sense of the person in their focus of diagnosis, where they were overly respectful of



medical authority. These prejudices of mine were magnified when I had to immerse myself in the participant observations. Did the therapists pick up any of my negative reactions? To what extent did that effect my relationships with them? Did it impinge on trust? As I got to know the physical therapists better, my prejudices were duly challenged and my respect for them grew. If I conducted the research now, at this point of time, it is likely all this would be less of an issue.

And how did all this influence my analysis? Throughout the individual and generic analysis I was aware of similarities and differences between the different types of occupational therapists. To what extent did I see these differences because I was expecting them? My findings seemed to reflect common stereotypes such as physical occupational therapists being more pragmatic and efficient, mental health ones being more creative, and so on. Have I simply reflected these stereotypes or have I constructed them? Do my findings reinforce and collude with the stereotypes that abound within the profession?

\* \* \* \* \*

At a practical level, the interactions and relationship dynamics between myself and my participants clearly influenced the stories that emerged. Three examples stand out :

- 1) My interview with Paula felt largely out of my control. She talked a lot and quite quickly, such that I did not feel able to get a word in without being assertive. Yet I was content to simply listen and let her take the interview where she chose. I



warmed to her and enjoyed her company. Also, as much of the information was new to me I was interested and worked to understand.

- 2) In contrast to Paula, Jane was much more reticent and reserved. She did not initiate any disclosures, which in turn made me much more active. I felt pushed to ask more questions and I became (reluctantly) much more directive. In the process I ended up asking what was for me an unusually large number of closed questions. Did I sense a vulnerability in her and, by asking closed questions, was trying to protect her from disclosing too much? Interestingly, Jane, more than any of the other therapists, got me disclosing more *to her*. She took the initiative to ask me questions, and I obliged, partly in my desire to share something with her in return. I also felt a need to confide in her. From the first moment I felt drawn to her as a therapist and as a beautiful woman. Somehow I wanted a part of her niceness and nurturing - perhaps even be her client? At the same time I could see that her general 'niceness', combined with her controlling quality (with her asking me questions) and lack of self-disclosure, were all effective defences in stopping me from pushing/challenging her. Jane and I together seemed to be engaged in an exercise to stop me probing too much.

- 3) The interaction was again different when I came to my interview with Karen.

Somehow in this interview we were both going through the motions with touches of mutual apathy. She started by indicating she wasn't terribly interested to be interviewed (she had stepped in for another occupational therapist who was off sick) and would be relieved to keep the interview down to one hour. I, in turn, felt equally content to leave it there. The hour passed and there was a sense of keeping the interview on safe, superficial topics. I somehow couldn't get interested in what



she was saying, and I couldn't get her on to topics I was interested in (like speaking directly about specific patients). We were pleasant to each other and Karen seemed open enough, but somehow something was missing. I missed the sense that we were both engaged on a voyage of discovery. Instead Karen was describing her role fairly unreflectively. A lot of what she covered was the kind of thing she might have said to any visitor and that response did not help my interest/motivation. This is likely to have influenced both the data collected and the depth/quality of my analysis.

\* \* \* \* \*

The notion that the research participants are legitimate and full participating members of the research carries with it a number of practical implications. For a start, I have felt the need to involve participants in a spirit of openness, reciprocity and egalitarianism. In practice this is easier said than done, given the fundamental inequality where one person (myself) is asking questions and setting the agenda, whilst the other is invited to disclose personal information. For this reason I chose to 'share' some of my findings with the participants. I gave a transcript of the interview to each therapist concerned and invited them to come back to me if they had any comments. I shared with Mary my analysis of my interview with her and I also let Jane study my analysis of the participant observation with her. As part of this process, I asked for their response. It is perhaps significant that no one disagreed with anything I had said, or felt able to challenge me : Mary went so far as to say I knew her better than she knew herself! In a sense she handed me the role of 'expert' and it had not occurred to her to disagree. The absence of dissent or challenge was at one level reassuring. But if I was not 'off



the wall' with any interpretations, I would not want to make any stronger claims. What is more important, I think, is sharing the transcript/analysis established a degree of mutual trust and openness. That seems a pretty good start for any research relationship.

Beyond the example of explicitly gaining participants' 'validation', throughout my research there has been a sense of being engaged in a *mutual* voyage of discovery. We have all been participants in the work. For instance, both Mary and Jane said they had learned something about themselves through reflecting on my questions and reading my analyses. Others have said similar things. Cathy, for example, thought her interview contained much that was new and "very useful". Initially, we had shared a fair amount of laughter and in-jokes. She spoke reasonably easily and I showed her I 'understood' and could identify with her community mental health experiences. As the interview progressed, however, I started to probe and challenge more, covering topics she had never thought about before, which left her questioning why she did things a certain way. This, I think, shows how the research process can itself change that which is being researched.

The next step would be to co-opt the participants as co-researchers or co-analysts where their own interpretations develop mine. This reflexive dialogue was evident to a small degree throughout all the interviews and observations as the occupational therapists were being asked to reflect on their reality.



## Summary

In this section, I have tried to show how my behaviour and reactions as a researcher have both affected, and been affected by, the world I am studying. Clearly, I have influenced my research. I have participated in every stage of it, from research design, data collection and analysis to write up. Using examples of methodological, personal and social reflexivity from my research, I have demonstrated how reflexive analysis can be exploited to unfold deeper understandings. As researchers, we are part of the equation; we need to look inwards as well as out. In a real sense, the research has been a joint product whereby my own and the participants' meanings have been negotiated. I have thus assumed responsibility to locate my findings as arising out of these relationship dynamics.



## 4.4 SUMMARY : THE LIFE WORLD OF THE OCCUPATIONAL THERAPIST

The life world or *Lebenswelt* - the world as encountered in everyday life - can be described in terms of existential dimensions we all share. We all have a self identity, we are all embodied, we all engage in relationships with others, and this all takes place within certain spatial and temporal boundaries. Within these general dimensions, the individual's life world is always unique, rich and complex. Each of us engages in multiple activities, roles and relationships all set within different social contexts. We experience our world at different levels and react in different, often confused ways.

These 'truths' apply also to the occupational therapists. Whilst they share certain common experience, they each engage with their world differently. The picture is further complicated as meanings and ambivalent emotions shift within and between the individuals.

The following analysis attempts to describe the occupational therapist's life world in terms of key existential dimensions of : i. the therapist in relation to self; ii. the therapist in a body; iii. the therapist in relationship to others; iv. the therapist in space v. the therapist in time. An attempt will then be made to capture the whole essence of what is like to be an occupational therapist.



## **The therapist in relation to self (i.e. self identity and sense of being an occupational therapist)**

Occupational therapists' sense of professional identity is confused. They are uncertain about the meaning of occupational therapy. They search for an identity. They struggle to negotiate the boundaries of their ambiguous role - a task made more difficult in a changing health care context. Whilst they embrace their profession's values, they are also ambivalent, to the extent of rejecting certain elements of occupational therapy. They turn away, seeking new, potentially more valued roles. They struggle to apply their holistic values in a work context which demands more efficient, reductionist practice. Feeling misunderstood and under-valued by others, they internalise others' dismissiveness, and this damages their sense of professional self-esteem.

But the therapists are committed to their mission to help others. They value what occupational therapy can offer and believe that it can make a significant and meaningful contribution in treatment. 'Doing occupational therapy' is experienced as being satisfying, interesting and enjoyable, though often difficult. They enjoy their craft, using themselves as treatment tools and participating in treatment activities. They are challenged by the problem-solving process which draws on both creative inspiration and scientific techniques. Whilst the daily therapy routines can be boring and/or frustrating, they take much pleasure in achievement. The therapists are particularly thrilled when they see any transformation in their patients/clients. Playing a part in enabling change helps them to know they are effective and valued, and it raises their professional self esteem.



## **The therapist in a body**

The therapists deploy their bodies in different ways - naturally, consciously and inadvertently.

Therapists' bodily presence, expression and touch communicate and connect with patients/clients. Through body language therapists present as people to be trusted, people who care. Through their touch they express support, comfort, warmth and mutual friendship. They handle, lift, hold and embrace their patients/clients, both physically and mentally, in order to give treatment and keep them safe. In these ways the therapists use their 'trusted-healer body' as a therapeutic tool.

Behind the 'trusted-healer body' is a 'scientist-professional body' which is more clinical, analytical and distant. This body carries keys, wears a white uniform, sits behind a desk. It also observes patients/clients - examines, probes, diagnoses. In these ways therapists display status and power - a remote image they also seek to counteract.

Therapists, however, must resist too much intimacy or face the danger of becoming a 'sexual body', an object of both love and lust. Body tensions are experienced as the therapists struggle to find the balance of being personal with their patients/clients, without being sexual, or being perceived as sexual. They have to be careful about when they use touch and how it will be received. The therapists are aware they may be seen as attractive and desirable. Although they may want to be attractive, they seek to deny their sexual body as it contradicts their other bodies. In addition, for women



therapists, their sexual body is a vulnerable body as it can be threatened and invaded.

When they come to work, they prefer to leave this more personal body at home.

Finally, the therapists seek to give, nurture, reassure, enable and care. As patients'/clients' express their needs, so the therapists respond. But sometimes more is taken out of the therapists than they feel able to give. At these times their bodies can feel invaded, grabbed at and sucked dry. In this way, the therapists engage a 'mother body' - one who can feel both loving and exhausted.

### **The therapist in relation to others**

The therapists experience both satisfaction and struggle in their relationships with their patients, the treatment team and the wider management/health care context.

Relationships are experienced as both supportive and as a power battle.

With patients/clients, they engage in a caring, empowering, intensely personal relationship in which they give of themselves. In return, they get close to, and identify with, their patients/clients, gaining much pleasure, warm feelings and a sense of being valued. At the same time these relationships can be experienced as a battle for control and a source of stress. The patients/clients can be demanding, threatening, abusive, manipulative and difficult to deal with.

Within the team the therapists also experience mixed feelings. On the one hand, they experience a mutually supportive collaborative relationship where they share in team



decisions. The team gives them a sense of identity and a secure base from which to cope with the daily grind. But as they seek to be acknowledged and valued, the therapists can also find themselves engaged in competitive power and status battles with other team members. Team conflict can feel damaging and impose more pressures as the therapists negotiate different demands and relationships.

The therapists feel most under-valued and powerless in their relationships with the management hierarchy and within the wider healthcare context. In the face of policies, resource constraints and change (where their very jobs may be at stake), they struggle to be valued and respected as fully fledged professionals.

## **The therapist in space**

The therapists' sense of space is experienced in terms of having to negotiate different boundaries :

- 1) They grapple with the reality of hospital versus community environments and what this means for patients/clients and their treatment plans. Beyond their sense of how these environments contrast physically, they view themselves and their work in different ways. For instance, in hospital their patients/clients are 'patients' whereas in the community context they are individuals, people with social lives. Where the therapists are involved in longer term rehabilitation they evolve a vision of those patients/clients in terms of the broader community context.



2) Therapists are engaged in negotiating their professional role boundaries and carving out territory for themselves. Here, they struggle to identify their legitimate professional activities, for instance, the extent to which they should employ counselling and move away from 'activity based' treatments.

3) The therapists' personal-professional boundaries need to be navigated. These boundaries assume particular significance within their relationships with patients/clients. Here the therapists struggle over how deeply, intensely or emotionally involved they should get as opposed to maintaining pragmatic, technical or professional distance. They have to negotiate the uncertain space between enmeshment and detachment.

4) The therapists experience different levels of autonomy, freedom and isolation according to their different work space environments. In the community, therapists are more independent; they move freely and autonomously, visiting people in their homes. But working alone means more responsibility and risk. Hospital therapists enjoy relative safety but are more restricted by the continuously 'peopled' space and prescribed, institutionalised routines.

5) Finally, the therapists negotiate spaces involving different levels of safety and threat. Where work is experienced as stressful - as a result of particularly challenging problems, abusive patients, or conflicts in the team - they seek refuge in their 'safe' places. This means something different to each therapist. It can mean time in a supportive Occupational Therapy Department away from a hostile ward; or being back with the team to off-load; or retreating to some quiet, private space in order to marshal resources.



## The therapist in time

The therapists' sense of time can also be conceptualised in different ways. Firstly, the therapists have an immediate sense of 'time' in terms of the pressures they are under. Here they have to cope with intense pressures of too many referrals and not enough time. They are focused on trying to carve out and manage their time which passes altogether too quickly. They try to manage their time by pacing themselves, balancing the fast, stressful challenging moments with having slower, easier, routine times.

Time is also experienced in terms of the time-scale for treatments. Significantly, the therapists value opportunities to get involved with patients/clients in the long term. Becoming involved long-term is more challenging and rewarding as it means getting to know the 'person' and exercising a broader range of their occupational therapy skills. However, management demands and practical constraints force the therapists into more short-term, contained, reductionist treatments. These somewhat boring, routine treatments are viewed pragmatically but often experienced as futile.

At a different level, time is experienced with a long view, in terms of past, present and future journeys. Therapists apply this sense to both their patients/clients and themselves. Within the treatment process, the therapists envisage their patients'/clients' past and present functioning and construct a story of how they might be enabled to change or cope better with their future. For themselves, they are aware of the lessons learned in the past from college days and how they have accumulated professional experience, in particular learning to reconcile ideals with the harsh realities of practice in the present.



One reality the therapists all grapple with is the threats to their own professional survival in an uncertain future world. This uncertain future contributes to making the therapists feel fearful in the present as they struggle to define their professional existence. They seek connections between past understandings (for example, those gained from college) and beliefs about future needs. But often there is a disjuncture of images which need to be reconciled in the present.

\* \* \* \* \*

In summary, the therapists are engaged on an honourable mission to help and enable others. They are committed to their holistic person-centred professional values and believe their occupational therapy craft promotes positive, health-enhancing change. As they seek to enable, support and connect with others, they are personally challenged by their intense relationships with clients and professionally challenged by relationships within the team. Assaulted on all sides by pressures of time, abusive people and lack of professional recognition, they get damaged. They struggle with their feeling of low professional esteem. Their sense of achievement when they enable someone to change, when they feel they have made a difference, helps them to regenerate. They are healed by mutually supportive, valuing relationships with patients/clients and team members. Throughout all their different satisfactions, challenges and struggles, the therapists are engaged in a search to find themselves and learn to cope in their uncertain world.



## 4.5 *REFLECTIONS ON THE PROCESS OF ANALYSIS*

The process of thematic analysis involved three stages :

- Stage one entailed doing an individual phenomenological analysis of each interview/observation in turn.
- In stage two, I looked for commonalities across all the individual analyses and attempted a generic analysis, highlighting key themes, issues, tensions.
- Stage three involved distilling the generic analysis down to an essence of four core global themes.

Each stage involved different tasks and demanded different skills. Not surprisingly, I encountered each differently, experiencing a range of satisfactions and difficulties as the work evolved. In this reflections section, I would like to give a personal account of my experience of this analysis process.

### **Stage one : Struggling with the individual analysis**

After each interview I would write up field notes (including my reflections diary) and then transcribe the interview in full. This data was used as the basis for my individual analysis. The whole process from beginning to end took about three weeks for each interview. Once the individual analysis was complete I would be ready to move on to the next interview. The participant observations were similar except that I wrote notes recording my observations and reflections throughout the week of experience. I saw my supervisors regularly during these individual analyses to discuss my experience and findings and to benefit from their feedback and guidance.



This was a period of learning - a steep learning curve. It was all so new, and it was evolving; the ground seemed to shift with each interview. I approached each interview in a completely different way. In part this was a deliberate strategy, an attempt to allow the themes to emerge; but it also reflected my own uncertainty about how the analysis could or should look at the end. Each step seemed to demand new learning and I struggled with everything. I had to grapple with new technology and learn to use the computer, new software, spread sheets and so forth. I also had to learn how to analyse. But this wasn't simply about having to learn a technique; it involved experimenting with different styles. I had to evolve a style that worked for me and that emerged out of the kind of material I was getting. I also had to resist jumping into explanation and try to stay with description. More particularly I had to work at staying with describing the individual and not comparing the individuals with each other at this stage. Overall, this was not an easy period.

At the level of learning technique, I struggled with learning how to analyse, in particular how to work with meaning units. Initially, I found the process of reducing the transcript into meaning units rather mechanical. Rather than enabling me to 'dwell', the process seemed to entangle me in words, and did not allow a feel of the person to come through. Eventually I dropped using the meaning units in the actual analysis. However, their use had been a good discipline and I retained the technique of taking time to focus on certain phrases. I felt some relief when I gave myself permission simply to write my analysis as prose rather than get caught up with numbered meaning units.

My biggest struggle, however, was coming to terms with what was meant by phenomenological analysis. I started by having no idea - a point confirmed by my



supervisors who gently suggested how I could improve. With each 'next interview', I would feel my analysis was improved, that I had captured something a bit more. But still the feedback I got was that I wasn't there...yet. I had not yet developed a phenomenological sense. Where was my empathy as opposed to my 'outsider' analysis? Where was the life world? What about the therapists' sense of temporality and spatiality? These were good questions and I didn't know the answers. In fact, early on, I didn't even really understand the questions! It was a strange time : painful and frustrating; but also stimulating and challenging. After my many years of teaching - in which I was the one who 'knew' - it was perplexing but also rather fun to be the one who was confused!

It wasn't until my first participant observation, which took place after interview 5, that I started to feel I was beginning to get a sense of my task. I believe this came about as I had I started to do more in-depth reflections and reflexive analyses at this point. Somewhat paradoxically, doing this more personal analysis allowed me to be more empathetic and enabled deeper insights into others' situation. My sense of Jane being 'in love with her car' was a key moment where, using my perceptions at different levels rather than just focusing on what was said, I seemed to capture something quite significant. Then my interview with Stephen prompted such mixed personal reactions I really had to start looking deeply and begin a more explicitly reflexive process. By the time I hit interviews 8 and 9, I felt I was succeeding in my attempt to express more of the ambivalences and ambiguities. My analysis was much less clear-cut. I was beginning to capture the flavour of certain phenomenological moments. I felt able, for example, to capture Julie's and Jenny's feelings of being sexually threatened by their 'creepy' patients.



At last I felt I had grasped the nature of phenomenological analysis - in particular, understanding something of these temporal/spatial/relationship dimensions. Feeling more confident and comfortable I returned to my first interview with Mary and re-analysed that. What a difference, a transformation! It was so much easier, yet at the same time what I was doing seemed more profound and complex. It felt exciting that I was really able to capture some essences, for instance, the 'tear' Mary was experiencing in her feelings of connectedness to other team members. In some ways it was very rewarding to see my learning so clearly on display. At the same time I recognised, somewhat ruefully, that I was going to continue to learn, develop and change and that probably if I repeatedly returned to any one interview, it would continue to be different on each occasion.

### **Stage two : The generic analysis - letting go, moving on**

My move to stage two, the generic analysis, was also not without angst. First of all, it was a slightly scary time in that 'moving on' meant getting down to the 'real' work of the thesis. It also meant a new type of analysis, and so new, unexplored territory. Once again, I didn't know what was going to emerge and I didn't know how I was going to do it. I was also anxious in that by moving to the generic analysis, I was saying I had done enough with the interviews. Yet it didn't feel as if I had finished. I was just beginning. The rational side of me realised this could be an unending process and I could see the sense of drawing some lines. I was also beginning to lose motivation as I contemplated having to re-do all those analyses again. The temptation was to temporise.



Once I got down to the analysis, much to my surprise the work progressed reasonably swiftly. Common themes seemed fairly easy to spot - a revelation, as I had deliberately avoided reading across and comparing all the analyses until this point. A structure emerged fairly quickly : I identified nine key common areas/experiences, with further sub-themes emerging. I felt I knew what I was trying to achieve; for instance, I worked to bring out the inconsistencies and tensions in the therapists' stories.

My main problem was my reluctance to 'let go' and lose the individual voices in a process of finding general essences. Somehow I had spent three years getting to know these individuals in all their richness, with all their idiosyncrasies. Was all that going to be wasted? As an initial compromise I resolved to include a summary of the individual 'stories' as part of the analysis section in the thesis. Eventually, I was even able to let go of this - but not completely, as I retained their individual voices in my quotations. It somehow ensured the individuals were still there.

### **Stage three : The gestalt**

Stage two glided imperceptibly into a more global stage three analysis. For one thing I hadn't planned on having this stage. It just happened. I had started with nine themes; now suddenly, I seemed to be possessed. I was ripping the themes apart, cutting out repetitions, then gluing them together in different ways. It would have been traumatic, had it not been so stimulating. The hard part was to take my supervisors' advice and let go of some of my 'gems'. I discarded my 'good/bad patients' theme and also the theme of 'coping with the emotional assault'. But I knew this destruction was necessary if I was going to create something better.



What was emerging in the new structure was my actual thesis themes. What an exciting time! Suddenly pieces were falling into place; unlooked for links were being made. I had a sense of purpose and direction. Somehow after four years of gestation I was ready to write. The material was all there in me and it came together sweetly. I enjoyed the sense of creating afresh and distilling down to the fundamentals. More importantly, I felt satisfied that somehow it did work. This was confirmed for me when I wrote the (section 4.4) summary of the life world. I believed I had managed to achieve a reasonably deep level of insight.

Of course I also had my doubts. Had I packaged the themes too neatly? Had I got the balance wrong with too many quotes and not enough analysis? Did the newly juxtaposed themes work? Were the links coherent or perhaps over-constructed? Had I gone too far with my metaphors? How could it all look so simple when it was built of layers of so much sweat?! What was missing? Were the themes 'life worldly' enough? Had I done enough to capture a sense of insider-first-person rather than outsider-third-person?

I kept returning to the question : Does this reflect their experience? It seemed to me that it did and I clung on to that reassurance. I knew my themes would never be complete. For one thing, I knew I had not begun to touch more personal-private (i.e. non-work) elements of the therapists' life world. Also, I knew I was never going to capture the insider perspective fully. This remains 'work in progress'. My analysis can only be a glimpse a partial, tentative, momentary snapshot. My hope is that it is also one rich in detail.



## 5. DISCUSSION

### 5.1 INTRODUCTION

This discussion aims to : a) relate my findings to the literature review; b) critically evaluate the methodology employed; c) explore the implications of my research.

- Section 5.2 explores the themes that have arisen in the previous section and relates them to the literature review. I attempt to highlight key areas of overlap or divergence between these and to indicate areas of possible future research. Two over-arching dimensions are explored : the occupational therapist's identity (or the relationship with occupational therapy); and the occupational therapists' relationship with others. A third section questions the very notion of 'life world' and discusses it. A fourth section explores how the life world is fundamentally embedded in a social context and contrasts how this can be understood from both a phenomenological and a social constructionist perspective.
- Section 5.3 offers a broad methodological evaluation including a critique of my research method, findings and methodology as a whole.
- Section 5.4 contains my subjective reflections on some of the issues raised by the discussion. In particular, I explore the implications and relevance of my research to occupational therapy.



## **5.2 THEMES RELATED TO THE LITERATURE REVIEW**

### **5.2.1 The occupational therapist's role identity**

Perhaps the most powerful message to emerge out of the research is occupational therapists' confused professional identity and their ambivalence about occupational therapy. They all seem to love and believe in what they do, yet they do not particularly understand it. They find meaning in occupational therapy values and practice while at the same time turning towards other roles. They desperately seek professional recognition and to be valued, yet at the same time cannot articulate what they value about themselves. They seem to have internalised others' lack of understanding of their role whilst also enjoying some status. The therapists come across as being strong and empowered. They know how they want to practise, yet they are simultaneously fragile and lack professional esteem.

The literature does not quite encompass these ambiguities in that the focus tends either to be on role confusion or on a kind of professional celebration where roles are asserted clearly. However, when the literature is taken as a whole the mixed messages come through. Several studies have clearly recognised the tensions between positive and negative elements of practice (for instance Hasselkus and Dickie's 1990 and 1994 explorations).

The occupational therapy identity and role is multi-faceted. In order to begin to understand some of the complexity, four different aspects will be examined in this section :



- the pleasures of being an occupational therapist
  - frustrations with the occupational therapy role
  - holism : romantic fiction or ambivalent struggle
  - diverging or converging life worlds?
- 
- The pleasures of being an occupational therapist

The pleasures of therapy practice have been well aired in the literature. Attention has been paid to how the therapists believe in and enjoy their work, and how enabling others to change is experienced as satisfying.

All the occupational therapists who have participated in my research seem to love their work and believe in what they do. They value the professional training they have had. They are committed to holistic, client-centred values and their mission to enable others. They are motivated by their belief in occupational therapy values including a holistic focus on independence in occupation. These findings are in tune with those of other researchers, including Creek (1996), Hagedorn (1995), Yerxa (1967), Finlay (1997a) and Hasselkus and Rosa (1997).

Similarly, the therapists in my study all seem to celebrate their role of promoting health enhancing change. They enjoy working collaboratively with active patients/clients, rather than subscribing to bio-medical models where the patient adopts a sick role (Adamson et al 1994, Jenkins et al 1994, Yerxa 1983). The mutual collaboration model of working also fits the current themes in the broader health care literature (for instance, Davies 1998a, Hugman 1991).



That the occupational therapists in my study gain a deep sense of satisfaction when they are able to bring about change has also been explored by other researchers (e.g. Hasselkus and Dickie 1990, 1994, Rosa and Hasselkus 1997, DePoy and Merrill 1988, Bordieri 1988, Brieness 1989). As this was such a strong theme it would have been surprising if the professional literature had not endorsed it. In all these studies, the stories of change reported were understood to be the telling feature of whether practice was experienced as satisfying or dissatisfying. In my research, the therapists associated changes observed in their patients/clients with feelings of competence and effectiveness - the greater the struggle and challenge, the greater the sense of achievement if there were successful outcomes.

The fact that therapists get a 'kick' out of doing occupational therapy and that they enjoy their craft is reflected in the literature on satisfying dimensions of practice (Hasselkus and Dickie 1990, 1994). Also recurring in the literature is the satisfaction the therapists gain from : a) being creative and overcoming challenges; b) the variety in their work; and c) the pleasurable aspect of participating in treatments. However, whilst the taking of pleasure in particular treatment has been noted by the researchers, the exact nature of how therapists 'heal' and what the 'moment' of therapy means, remain unexplored. An individual therapist's sense of what makes him or her effective (for instance Julie's sense of warmth radiating out from her) or what makes a treatment feels 'right', has not really been specified. Pursuing these themes may help us understand better what makes for effective practice and satisfied therapists.

Although not explicitly explored in my interviews, the occupational therapists' clinical reasoning, their use of narrative and their savouring of complex rational-intuitive problem-solving emerged strongly, particularly in the participant observation. The



occupational therapists' complex patterns of clinical reasoning seemed to reflect those indicated in the literature - particularly Fleming's (1994a) three track reasoning, Mattingly's (1991) narrative reasoning and Schell and Cervero's (1993) pragmatic reasoning. The phenomenological way in which therapists think - how they envisage their patients'/clients' situation and construct narratives about their past, present and future lives (Mattingly and Fleming 1994) - is a critical point. Also, the way therapists used intuitive, spontaneous problem-solving rather than systematic reasoning came through. This was the therapists' art as opposed to their science (Benner 1994, Schön 1983).

One aspect of practice which emerged from my research but which is not often expressed in the literature is the satisfaction therapists gain from having a degree of status and authority. For example, the physical therapists observed seemed to gain a sense of insider identity, even power, from their uniform. This was but one aspect of a much broader striving towards being seen as a legitimate therapist with associated professional authority. Whilst the professionalism literature (e.g. Hugman 1991) picks up on the issue of professional power and expertise, the notion of professionals gaining satisfaction from their power is often not discussed (and may even be seen as a taboo subject).

- Frustrations with the occupational therapy role

The more problematic dimensions of the occupational therapist role demonstrated in my research have also been well explored in the literature : in particular, the recurring



theme of the therapists' angst about their role and search for an identity (Creek 1992, Lycett 1991, Thorner 1991, Lloyd-Smith 1994, to cite but a few).

The occupational therapists have struggled with these problems in different ways :

- 1) They are not clear about what occupational therapy is and means. Further, few of them seem to have a clear sense of any profession-specific core of theory, despite valuing much of what they have been taught at college. Their confusion seems amplified by the mixed messages about what they should be doing that emanate from college, colleagues and management. They also find it impossible to apply the ideals learned in college to the 'real world'. Fondiller et al 1990, Barker and Baldwin 1991, Barnitt and Mayers 1993, Steward 1996 are among those to have explored this dimension.
- 2) The therapists have a fight on their hands to resist being affected by the way their role is misunderstood and by the negative stereotypes they are branded with (see Jenkins and Brotherton 1995, Harries and Caan 1994, Smith 1986, Chakravorty 1993).
- 3) The therapists struggle to carve out a role that is valued in the context of changing practice and role blurring (Kaur et al 1996). This is particularly so in the case of the community mental health therapists, who have relinquished their traditional role boundaries (see Øvretveit 1997 and Hopkinson et al 1998).
- 4) The therapists strive to feel 'legitimate' and struggle against feeling that they are failing. The literature does not capture the way the therapists seem to internalise messages that they are failing - messages which come both from the team and from patients/clients who do not change or who ignore advice. While the literature recognises some of the frustrations involved, it does not explicitly deal with the



therapists' sense of inadequacy or feeling like a 'charlatan' - perhaps this goes against the more powerful rhetoric of what it means to 'be a professional'.

The intense confusion created by the therapists not feeling clear and empowered in their professional functions, and the emotional impact of them of this confusion, has not really been expressed in the literature except in terms of the struggle to identify profession-specific theoretical frameworks (Kielhofner 1992, Creek and Ormston 1996, Feaver and Creek 1993). Interestingly, only one of the therapists studied in my research (other than myself) showed any awareness of this theoretical literature. For her, as for me, the use of theory as a foundation for practice (in particular the model of human occupation) seems to help eliminate the role angst experienced by others.

The way the occupational therapists in my study reject their identity is reflected implicitly in the literature with all the exhortations to unite and follow occupational therapy theory (Kielhofner 1995, Golledge 1998). However, the reality of how therapists engage in other roles (e.g. counselling) and seek other qualifications (such as becoming a drama therapist) is inadequately explored in the literature. While there is some discussion as to whether or not therapists should do these things, what is not explored is why they do do these things and what meanings are associated with them.

All the therapists in my study experience a degree of pressure and stress in terms of their work role. They are pressured both by the workload and by tensions associated with their professional status/identity. These factors have been well explored in the literature (e.g. Rees and Smith 1991, Sweeney et al 1993b, Allan and Ledwith 1998). White (1996) noted how professionals became more pressured and dissatisfied when they were unable to practice what they perceived to be their role.



Interestingly, none of the therapists admitted to feeling *overly* stressed - indeed, the pressure seemed to be accepted pragmatically as part of the reality of practice. The argument of Rogers and Dodson (1988) and Rees and Smith (1991) that occupational therapists suffer less than other professionals may be relevant here. This acceptance of a common experience of pressure brings with it a degree of acceptance of a range of coping strategies which otherwise might not find favour : for example, a more reductionist focus on patients'/clients' needs and prioritising treatments offered.

Several other explanations for how therapists seem to cope reasonably well can be put forward. Rogers and Dodson (1988) noted that therapists experience less burn-out as their use of creativity in activity treatment and the opportunity for positive social interactions with patients/clients probably guard against emotional depletion. Also, these therapists all seemed to have supportive, empowering and on-going supervision, offering them an opportunity to off-load feelings. Such supervision would do much to balance feelings of pressure, as Allan and Ledwith (1998), Parker (1991) and Leonard and Corr (1998), amongst others, have noted.

- Striving for holism : romantic fiction or ambivalent struggle?

Occupational therapy philosophy asserts that occupational therapy practice is holistic, humanistic and client-centred (e.g. Mayers 1990) Occupational therapists are said to view patients/clients as unique individuals and treat them as whole beings, attending to physical, psycho-social and even spiritual aspects. But to what extent does this rhetoric actually apply in practice?



My research has confirmed that the rhetoric of holistic client-centred practice is alive and kicking in that holism is valued, even 'deified'. However, what holistic, client-centred practice actually means is open to debate. Each therapist seems to understand it, and enact it, in different, sometimes contradictory, ways. Further, the therapist's practice can be simultaneously reductionist and holistic depending on the needs of the situation. Each therapist struggles to negotiate the tensions between theory and practice. While striving to be person-centred, he or she must also be pragmatic, realistic and strategic, given the demands of the work context.

All the therapists revealed a way of viewing clients which was multi-layered, complex and often contradictory. They all sought to be person-centred. Yet at the same time they stereotyped their patients/clients and reduced treatment to standard formulae. One interesting instance of contradictory responses emerged in the way that many of the therapists (particularly in mental health) rejected, but still used, medical diagnosis to categorise their patients/clients. The statement, 'we treat people not patients' was a commonly expressed sentiment and rejecting the use of diagnosis was seen as part of resisting more reductionist medical treatment models. In contradiction to this, however, these same therapists labelled patients/clients in other ways which in turn resulted in unreflective and stereotyped treatments. The contradictory use of diagnosis indicates how we can unintentionally soak up the discourse of the wider treatment team and context and how this can result in unintentionally disempowering representations and practices (Opie 1995).

As we try to make sense of these complexities, it is clear that the practical realities of the work context make it difficult to resist being reductionist in approach. The realities



of workload pressure mean that therapists have to compromise and be strategic about their interventions. It is no accident that therapists in acute hospital settings, facing enormous pressures to get through large numbers of patients a day, tend to classify their patients in more stereotyped ways. They have neither the time nor (arguably) the need to get to know the people behind the labels.

That therapists, in order to cope, pragmatically adopt more procedure-centred treatments, has been well documented in the literature (see Smith 1991, Strauss et al 1982, James 1992, Fondiller et al 1990, Barnitt and Mayers 1993). Barnitt and Pomeroy (1995) argue that the extent to which therapists are reductionist or holistic is a strategic choice set within a social context, rather than a philosophical stance; they suggest therapists' clinical reasoning is complex.

Interestingly, the way therapists like Susan and Stephen operated with concurrent identities, being simultaneously reductionist and holistic, seems to fit the pattern indicated in the clinical reasoning literature. Mattingly (1994) explored how occupational therapists think in terms 'blurred frames': bio-medical and phenomenological. Fleming's (1994) work on the three track mind endorses the idea that therapists approach their work with different world views. Taken together, all of this evidence substantiates the idea that therapists operate simultaneously in several modes.

The debate over whether occupational therapy is a holistic profession therefore emerges as somewhat sterile. The picture is more complex and dynamic; there are multiple meanings which emerge in different contexts. Rather than falling back on simplistic professional rhetoric, occupational therapists need to understand how holism



means different things, at different times, to different people (and professions). More research into the internal and external factors which enable therapists to be holistic or which push them into reductionist practice would seem to be called for. It would be useful for therapists to be able to distinguish those situations which require a holistic approach and those where it is unnecessary (Barnitt and Pomeroy (1995). Rather than striving unsuccessfully to be 'holistic', and then feeling a sense of failure, therapists could be empowered by recognising how different levels of both reductionist and holistic practice emerge out of, and co-exist within, a broader social context.

- Diverging or converging life worlds?

All the therapists seem to experience a world which is recognisably similar in that they are confronted with similar dilemmas and confusions. However, their solutions to these dilemmas change in different contexts. This diversity of practice and experience between occupational therapists in different work areas calls for comment, especially as this diversity emerges as a key explanation for the therapists' role confusion.

In my research, the commonalities regarding role identity between occupational therapists working in similar areas was striking, for instance, how the community mental health therapists struggled to define their role and how the physical hospital therapists reduced their focus to personal care activities. These types of role patterns brought the differences between the areas of occupational therapy into sharp relief.

Along with differences in roles, the occupational therapists seem to have different concerns depending on where they work. For instance, the mental health therapists are



less concerned with diagnosis, whereas the physical therapists start from this point.

Equally, the mental health therapists are preoccupied with coping with feelings whilst the physical therapists are preoccupied with coping with self care.

The treatment modality used by the therapists also varies in that the mental health therapists working in hospitals (and to some extent those in the community) experience much of the therapy process in terms of activity sessions and group therapy. All the other therapists engage more with one-to-one treatments. The type of treatment employed has implications for the nature of the relationship they develop with patients/clients and how they use themselves in therapy.

Then there are differences in terms of relationships. The mental health therapists tend to have longer term relationships and in a way engage in deeper relationships as patients/clients disclose raw emotions and share intimacies. On the whole the physical therapists are less exposed to emotions and intimacy relates more to bodily functions.

The therapists working in acute areas tend, by definition, to see many more patients and so have more short-term, impersonal and even superficial contacts. The therapists working with patients/clients receiving continuing treatment tend to build more personal relationships.

The therapists also vary in terms of relating to patients/clients at a bodily level. The physical therapists use touch frequently and pragmatically as they lift, handle and transfer patients. Their greater concern with bodily functions (such as toileting) puts the patients'/clients' body at the forefront of the agenda. The mental health therapists often ignore the body, except when engaged in teaching breathing techniques for



anxiety management. However, touching may take place to offer reassurance (a quick hug) or may be demanded, as Mary found to her cost when she was grabbed at.

Perhaps the most striking differences occur with regard to temporal and spatial aspects of the life world :

- a) Workload - While physical therapists suffer particular pressure on their time in terms of the number of referrals and pace of work, psycho-social therapists are more pressured at an emotional and relationship level.
- b) Autonomy - Community therapists have considerably more autonomy and personal space as they travel around visiting people in their homes. They all feel positive about their autonomy and ability to make independent decisions. On the negative side, they are more isolated than hospital therapists, and in some ways their space is more dangerous. Sole responsibility for carrying out treatments feels more risky. Hospital therapists, on the other hand, are more restricted. Their timetables are fixed by hospital routines and decisions are always taken in tandem with other team members. Responsibility is diffused and the sense of being pressured is therefore reduced.
- c) Freedom - The community therapists' work in the community means they are exposed to a greater range of 'normal' life. They also have more freedom to take part in this life - for example, by joining community action groups - as their travelling takes them out and about. The hospital therapists are more trapped within the walls of their institutional (or institutionalised) space. This sense of being caged is particularly acute in the locked forensic unit, from which therapists escape with a sense of relief.
- d) Isolation - Similarly, community therapists travelling about in their cars have a great deal more personal space. In Jane's case, the car symbolised time for



reflection, peace, safety and independence. For the hospital therapists, space is always 'peopled'. They share offices, go to meetings, work on a ward with others, treat groups of people together, and so on. They even change in and out of their uniforms together! The constant (and, to a degree, enforced) interactions with others increases the pressure on them. However, the isolation and risk associated with working alone also bring pressure - albeit of a different nature - for the community therapists.

Overall, the patterns of role involvement that emerge from my research are in tune with those identified in the wider literature. In particular, the divergence between mental health and physical therapists identified by Creek and Ormston (1996) is clear. Mental health therapists are more able to implement holistic, client-centred practice where health needs are not separated from social ones. In contrast, physical therapists (particularly in acute sectors) tend towards being more pragmatic, didactic, task-orientated and arguably more reductionist in approach.

The divergence between hospital and community practitioners is also explored in the literature (see for example, Feaver and Creek 1993 and Pimental and Ryan 1996). The hospital therapists are clearly more bound, than community therapists, to working within a medical model framework and hierarchy. The stresses they experience working in such an environment have been identified, particularly by the nursing literature (Menzies Lyth 1988, Adamson et al 1995). The community therapists have different struggles : they have to carve out new roles in the context of role blurring and the competition between team members. These struggles have been well documented (Øvretveit 1997, Hopkinson et al 1998). However, the isolation of



community practitioners and their struggle to cope in the face of daunting social problems, remain surprisingly unexplored by much of the literature.

Research is also relatively thin on the life worldly aspects of the temporal, spatial and embodiment dimensions. Arguably it is this type of analysis which can capture the commonalities and differences of day-to-day practice most sharply. There is a strong need for more research in this area as the debate continues as to whether or not occupational therapy can remain a unified profession.

### **5.2.2 Caring-power relationships**

The therapeutic relationship is at the core of the therapist's life world. It is seen as fundamentally influencing positive and negative treatment outcomes (Swartzberg 1993) and a potent source of identity, meaning and renewal for therapists (Hasselkus and Dickie 1990, Ramos 1992). While all therapists in my research care for and about their patients/clients (Smith 1992), they do so in the context of a relationship that is essentially instrumental and unequal. Therapists seek their patients'/clients' cooperation, in the process relinquishing some power. But, ultimately, they retain control (Crabtree and Lyons 1997, Lyons 1997, Kalyanpur and Rao 1991).

Taken as a whole, the literature does succeed in capturing much of the ambivalence occupational therapists experience in their relationships : how dimensions of care and



power are negotiated simultaneously *both* in dealings with patients/clients and with other team members.

The life world of relationships with others involves numerous, diverse, multi-faceted interactions. In an attempt to unravel complexities, five different aspects will be explored :

- the challenge to care
- use or abuse of power?
- 'good' patients, 'bad' patients and social evaluation
- team members : friends or foes?
- coping with the assault.

- The challenge to care

The therapists in my study seem to strive continually to connect with their patients/clients and establish an inter-subjective understanding - a point similarly expressed by Crepeau 1991. The therapists express their caring in the way they try to help and be concerned, and in the way they share in, and celebrate, patients'/clients' gains. As Rosa and Hasselkus (1997) found, they seem to want to give of themselves and their professional skills, and to do so in a context of a mutual give-and-take.

However, much effort goes into managing this giving, for personal-professional boundaries also need to be negotiated. One point to emerge strongly from my research is the challenge of managing the space between detachment and enmeshment. Some therapists were obliged to reconcile their desire for intimacy with the conflicting expectations of 'proper' professional distance. The lack of consensus as to what



constitutes an appropriate relationship makes finding this balance difficult. The desire to care versus the difficulties of caring, a running theme of my own research, is well explored in the literature (Morse 1991, Smith 1992, Lyons 1997 and Benner and Wrubel 1989).

Therapists' need to manage the relationship with patients/clients and limit the amount of care they give - in the interests of self-preservation - a point which also features strongly in the literature. Devereaux, for instance, comments that it is impossible to care for every patient/client and that failure to recognise this may lead to "emotional hemorrhaging" (1984, p.794).

What is less well explored is the intense emotional impact these relationships have on the therapist. Neither the deep 'loving' feelings therapists have (e.g. Paula weeping with the bereaved wife or Julie's expressions of love for her patients) nor the negative 'hating' feelings they can experience (e.g. Jenny's fear and loathing of the creepy patient) surface much in the literature. These extremes of emotions are touched upon (for instance Herbert and Weingarten, cited in Jarman et al 1997, recognise the sense of deep frustration and negative emotions therapists experienced about some anorexic patients) but they are largely given a gloss of professional justification. Raw loving and hating would normally be considered taboo and not an acceptable component of the therapeutic relationship.

This disjuncture between some emotions and personal/social/professional expectations may well result in feelings of guilt, confusion and distress. Ultimately the therapists are likely to deny or suppress some of the less acceptable emotions; they may, for instance, deny the existence of 'bad' patients. Lyons (1997) picks up some of these



tensions when he recognises students' distress about having to operate in an 'unnatural' way and their resistance to doing so. That these tensions need to be negotiated routinely is worthy of further exploration.

My research indicates that while broad agreement exists amongst health professionals about the value of caring and how caring should be managed, we need to be cautious about making too many generalisations. For one thing, 'care' means different things to different therapists - a point picked up in Purtilo's (1993) notion of 'meaningful distance'. For some therapists, care means being competent and maintaining a professional distance to ensure effective treatment. For others, to care means to love and be involved in a collaborative exercise. Some therapists act as a 'technician', others as a 'parent' or a 'friend'. These different representations of care have been explored by a number of researchers including, Peloquin (1990, 1993), Burke and Cassidy (1991) and Stewart (1990).

Secondly, each therapist enacts different types of caring relationships with different patients/clients depending on their needs and the situation. As one example, Jane used (or allowed) touch frequently with some clients but not with others. Crabtree and Lyons (1997) and Morse (1991) similarly studied how therapists express caring in a variety of ways, including the use of 'caring touch'.

Thirdly, relationships change over time. Clearly, where patients/clients are involved in treatment over a long period, the relationship with the therapist deepens. Detached efficient concern (Fox 1974, Bennett 1987) gives way to more involved, emotional investment. Interestingly, it is often those patients/clients with whom the therapist has had prolonged contact, who are experienced most positively. An example of this is



Stephen's preference for 'proper rehab patients' as opposed to 'bog standard' assessments. Other studies (e.g. Hasselkus and Dickie 1994) make a similar point.

Future research on the nature of caring in occupational therapy should acknowledge these complexities and avoid any easy prescriptions of 'ideal' relationships. Too often judgements are implied : for instance, that a mutual, collaborative relationship is somehow always better (Peloquin 1993, French 1994, Schön 1983).

- Use or abuse of power?

A professional's power resides, in part, in his/her expert knowledge. As Edleman (1977) puts it, "the professional has ways to ascertain who are dangerous, sick or inadequate, that he or she knows how to render them harmless, rehabilitate them or both; and that the procedures for diagnosis and treatment are too specialised for the lay person to understand or judge them." (cited in Miell and Croghan 1996, p.297).

Therapists, then certainly exercise a degree of power. They are considered to have the expertise to define and treat patients'/clients' problems (Lyons 1997). They have the power to direct, make rules, issue instructions, prescribe treatment (Roth 1984, Hewinson 1995). In an interview, the therapists ask the questions and they expect to be answered by the patients or clients. This is all a matter of routine. For all the rhetoric of mutual, collaborative treatment, the relationship is essentially unequal.

This way of operationalising power through expert knowledge has been well described in the literature. However, that the picture is more complicated can be illustrated in a number of ways.



Firstly, the notion of power is complex : different types of control are exerted. There is the overt control exerted by the therapists in my study when they enact their directive, advice-giving role. Power is also enacted more covertly through subtle manipulations and persuasions and through the use of language. A subtle control is also exerted in the way therapists seek to empower their patients/clients by giving them 'choices' whilst at the same time setting the agenda. Therapists must be controlling to guarantee self preservation. They use their authority to control stressful, unpredictable encounters with patients/clients; a case in point is Lyons' (1997) description of students who attempted to gain control over 'manipulative' patients. The many faces of power and control are just beginning to be reflected in the literature : for instance, in the work of Jarman et al (1997) and Morrison (1994).

Secondly, therapists' definitions of power vary in terms of what is acceptable use of power as opposed to unacceptable abuse. For instance, Karen's use of coercion to get patients to exercise (in her role as part of the 'firing squad') would probably not find favour with client-centred mental health therapists who aim for greater collaboration. The physical therapists on the other hand might well defend light coercion in terms of 'safety precautions' and see it as 'being in the patients' interests'. A fuller discussion of the nature of power in different social contexts would be a valuable addition to the professional literature. As matters stand, the view seems to prevail, in the literature I reviewed, that all power must be negative (e.g. Hugman 1991).

Thirdly, while the literature focuses on professional power, less has been written on 'patient power' within the therapeutic relationship (as opposed to collective activity and pressure groups). Yet therapists regularly feel controlled, even threatened, by some



patients/clients. All the therapists I met in my research have had experiences where they battled with a complaining or resistant patient/client (for instance, Jane's experience with the belligerent daughter) or with one who was explicitly violent/aggressive (e.g. Jenny's experience with the stalker). The point is that therapists get damaged; research has shown how this damage can lead to stress and burn-out (Cox 1988, Bailey 1985, Sullivan 1993, Sweeney et al 1993b, Adamson et al 1998).

Finally, the social context of power needs to be unwrapped. At a *micro-social* level of analysis we can see that the way power is exercised is actually negotiated within particular relationships. For instance, some therapists try to resist an authority role but still have it foisted on them by the client who seeks a 'nurturing parent'.

At a *macro-social* level of analysis we can appreciate that power arises in the context of broader social divisions and that these take place in a wider institutional context. Also, the routinization and bureaucratization of care, evidenced by the busy therapists' assembly line approach, can be seen as part of wider institutional practices which exert control over both patients and staff (Jones 1994). Formal hierarchies are cross-cut by both professional boundaries and structures of gender and race (Hugman 1991, Davies 1996). My research highlighted one way in which gender relations impacted, presenting examples of how male patients threatened female therapists. This aspect of gender has not yet been particularly well explored in the literature (Thompson, Clare and Brown's 1997 work is a notable exception) - probably because it ties into issues of sexuality - and professional sexuality is largely a taboo subject. It is interesting that sexual encounters between staff and patients are usually framed in terms of the 'pathology' of one party or other.



- 'Good' patients, 'bad' patients and social evaluation

Overall, the general images of 'good' and 'bad' patients carried by the therapists I studied seem to match the findings of other research. Amongst all the therapists there was a strong consensus that 'good' patients make them feel valued and effective. They are experienced as rewarding to treat because they change. This is all the more so when they are 'difficult', complicated or clinically interesting cases which challenge and test the therapists' skills/knowledge. Popular patients have bright, warm, responsive personalities and a good sense of humour. In contrast, 'bad' patients make the occupational therapist feel incompetent. Such patients may be boring, unappreciative, cold, unresponsive, manipulative or threatening. None of these findings are at all surprising and they surface in the literature. In particular, experiences of good and bad patients relate closely to experiences of satisfying and dissatisfying practice identified by Hasselkus and Dickie (1994).

It is perhaps significant that occupational therapists, striving to be accepting and client-centred, seemed to avoid using the 'moral' categories employed by the accident and emergency medics in Jeffrey's (1979) study. However, occupational therapists may well have their own version of 'rubbish' patients : namely, the ones seen as pointless, boring cases where treatment is likely to prove ineffective.

It would appear that occupational therapists, like other health professionals (to say nothing of people in general), frequently label their patients/clients and make social evaluations. Although occupational therapists may strive to be non-judgemental, some level of social judgement is unavoidable (Kelly and May 1982, Smith 1992). Some therapists felt uncomfortable about this and, like the nurses in Johnson and Webb's



(1995) study, they worked to ensure professional duties were not unduly influenced. The fact that social evaluations are inevitable suggests therapists need not feel guilty - particularly when the intention behind the social judgement is to ensure the best treatment. Arguably, therapists would do better to put their energies into identifying the occasions where social evaluation slides into more pejorative, potentially destructive moral judgements. An example of this is where the therapist avoids treating certain categories of people (such as substance abusers or those with a long psychiatric history).

Whilst there appears to be broad agreement about what constitutes good or bad patients/clients (or people), we need to be cautious about generalising too far. Patterns are not predictable and vary from individual to individual. For example, the general pattern suggests professionals do not like abusive, threatening, manipulative clients. But Jenny pointed out that some of her potentially aggressive, violent patients could be “good fun” and likeable on a “superficial basis”. Johnson and Webb (1995) noted individual variations, including nurses who reported a covert liking for patients no one else seemed to like.

We also need to recognise how social evaluations involve multiple, sometimes contradictory meanings. The same patient can be perceived simultaneously as ‘good’ and ‘bad’. For instance, the patient who is perceived as ‘boring’ or ‘routine’ may also be viewed positively as offering opportunities for straightforward, successful problem-solving. Susan admitted she was drawn to ‘difficult, manipulative’ clients who had been sexually abused as they aroused her clinical interest.



What also needs to be remembered is that the meanings of labels vary between individuals. What is a 'routine' case for one person may be 'special' to another. An 'emotional' patient might be seen as threatening and 'out of control' to one therapist, and as stimulating or challenging to another. In my research, I found that mental health therapists invariably experienced emotional patients/ clients with empathy and clinical interest, whereas for the physical therapists, like Stephen, they were to be avoided wherever possible.

Beyond the fact that different individuals ascribe different meanings to labels, the same individual may carry multiple meanings for the same label/evaluation. A case in point is the meanings of words like 'difficult' or 'demanding'. 'Demanding' can mean being unpleasant, being challenging as in a difficult game, or simply asking for that which is due in an aggressive manner (Johnson and Webb 1995).

Finally, it is clear that labels can change over time (Dingwall and Murray 1983).

Johnson and Webb (1995) make this point in their discussion of the well liked patient who, on one particular day, was seen as "grumpy".

- Other team members : friends or foes?

The multi-disciplinary treatment team offers an important source of identity, meaning and social interaction for the therapists in my study. Team relationships are also a prime source of support, helping to relieve stress. The therapists see themselves as working collaboratively and sharing in team decision-making. This vision of the team as a positive force is reflected in much literature (e.g. Sweeney et al 1993a, Hopkinson et al 1998, Leonard and Corr 1998, Robertson and Cummings 1991).



However, the team can at the same time be viewed of problems and conflict.

Therapists compete with others (often nurses) over territory and they vie for recognition within the hierarchy. Interactions with other team members can be experienced as stressful and disempowering - a point that is also picked up in the literature (for example, in Sweeney et al 1993a, McNeely 1994, Toulouse and Williams 1984, Hopkinson et al 1998). Within this battleground, the team is experienced in terms of power struggles in which therapists have to fight to be valued and respected (Hugman 1991).

The problems and conflicts in the team can be understood using three levels of analysis (Finlay, forthcoming) :

- 1) At a group level of analysis, it may be relevant for occupational therapists to consider unconscious group dynamics and how a team may put up psychological defences to combat anxiety. Following Menzies Lyth (1988), Loxley (1997) expresses this in the following terms :

Some social situations are experienced as so overwhelming that they can only be responded to by projecting the impotence outside, either on to the patient or client or on to particular personalities or another associated professional group or another agency. Suspicion, avoidance, scapegoating, stereotyping, denial, blaming, self-idealisation are all common defence mechanisms in the interchange between professions involved in individual or social distress (1997 p.57).

- 2) At an organisational level of analysis, the team may not have in place systems which can clarify the division of labour in terms of roles, responsibilities and how clinical decisions are made (Øvretveit 1997).
- 3) At a society level of analysis, the team can be understood to reflect wider social divisions in society (class, race, gender and age). The fact of working in a hierarchy where practitioners have different levels of status, power, pay and experience is a



potential source of tension (Kenny and Adamson 1992, Adamson et al 1995).

Further, in the context of marketisation (Jones 1998), the fact of competition between team members for their very jobs also underlies some team conflict.

Several of the therapists in my research admitted feeling hurt and surprised when first confronted with team conflict. They seemed to be inadequately prepared to deal with the problem. Further research on the challenge of team work, the causes of problems and possible strategies for overcoming these (as offered by Øvretveit 1997), seems called for - particularly in the current context of evolving practice and the emergence of a new, collaborative professionalism (Davies 1998a).

- Coping with the assault

All the occupational therapists in my research are assaulted by the demands of the health care system. Work is always demanding and perceived to be pressured. There are too many patients to see, there is never enough time. There is too much to do, and not enough resources to get them done. Contacts with negative, abusive patients/clients are threatening and emotionally draining. Similarly interaction with unappreciative, demanding team members is disempowering and exhausting. The therapists feel insecure in their jobs; they feel both threatened by and powerless against management priorities and government policies. They have no control over the wider health care changes that negatively impact on their patients and the work as a whole, for these are part of global political-economic processes.

To a degree, all of these pressures are acknowledged in the literature - it would be surprising if they were not. Fish and Coles (1998) provide a particularly graphic description with their metaphor of 'professionals under siege' - professionals who are



threatened, defensive, overloaded and highly pressured. Literature on stress and burn-out in the professions is also relevant here (e.g. Leonard and Corr 1998, Sweeney et al 1993b). Lloyd-Smith (1997) touches on the impact on staff of management changes and the shift to trusts, whilst Burnard (1991), Bousfield (1997) and White (1996) acknowledge the pressures on nurses that come from the wider organisation.

The broader sociological and social policy literature on the reconstruction of the health service, and the crisis within it, is also relevant (Davies 1998b). The rise of managerialism, market principles, hospital and community trusts, accountability, rationing and consumer sovereignty (discussed by Jones 1998) have had fundamental impact on therapists' practice. Management restructuring has resulted in loss of professional hierarchy support. New demands for efficiency have led to severe cost cutting, reducing the resources available and threatening jobs. Demands for effectiveness and accountability have prompted the development of practice standards, outcome measures and extra documentation. All of these developments have been challenging for the therapists and professions as a whole. However, at the level of individual practitioners these links are often not made explicitly. Therapists speak about 'pressure' but see this in terms of immediate overload rather than in terms of, say, market principles or the loss of professional support structures.

In line with this, the occupational therapy literature contains fewer references than it might to broader socio-political and economic trends. Perhaps Opie (1995) had it right when she suggested that, in the current organisational conditions, health professionals do not have the space to be reflective and reflexive.



In terms of how the therapists cope with pressure, a number of defences can be seen to operate, namely : routinising care, cutting off from emotions and labelling patients.

Whilst the pressures facing practitioners have been well explored in the literature, the 'solutions' are less frequently tackled. Limited information is available on the coping mechanisms therapists can adopt. Of the work that is available, Menzies-Lyth's (1988) study goes furthest, offering an account of defence mechanisms at work. Others, for example Lyons (1997) and Jarman et al (1997), have looked at the strategy of defensively taking control.

While some of the factors that enable better coping, such as supervision, interaction with team members and rewarding patient contact, feature in the literature, less well described are the idiosyncratic coping strategies each individual evolves. Peter, for example, develops and uses his protocols (in the form of self-devised interview schedules) to keep him clear and on track; Jane uses her 'car' as an island to recoup and recharge; Susan engages in 'covert' practice to cope with conflicting values between the service and herself. A number of the therapists, including Julie, Karen, Susan, Peter and Mary, value additional professional development opportunities and the 'time out' of being seconded to go on particular courses. While professional development as a way of enriching practice and raising professional esteem is well discussed in the literature, its valuable role in giving therapists space away from work is less acknowledged.

One quite powerful coping strategy used by therapists in my study is the splitting of professional selves (for instance as carried out by Stephen and Susan). Fleming and Mattingly (1994) pick up this point in their description of 'underground practice'. They identify how, in order to be respected, therapists were driven to focus narrowly on bio-



medical treatments. When given opportunities to be more holistic they took them, but often this was done covertly and not recorded :

Many therapists were masterful at understanding patients and the illness experience and helping patients to formulate, either through words or actions, deeper understandings of themselves and their experiences. Because they valued this work, they continued with it. But because it was not "reimbursable" they did not document it... This disjunction between what therapists do and what they report to others can put therapists in a difficult position. Their values concerning action, engagement, and quality of living in the everyday world often bring them into conflict (though often a silent conflict) with the values of the dominant biomedical culture held by other members of the clinic world (1994, p.296).

Fleming and Mattingly's research underlines how the institutional context fundamentally restricts the therapist's practice, funnelling therapy into acceptable channels and constraining creativity. Clinical reasoning about what would be in the patient's best interest "becomes inextricably mixed with reasoning about the politics of maintaining respect" (1994, p.297).

### **5.2.3 Is there an 'occupational therapy life world'?**

Taking the 'life world' in its most general sense, it is clear that the occupational therapists share a similar world to other health professionals. They are subject to the same health care context with all its attendant rewards, conflicts and pressures. They relate to the same range of people, be they patients/clients, team members or management. In this way it can be argued that much of their life world - their temporal, spatial and relationships dimensions - is shared. Does then, a specific occupational therapy life world exist?



The global themes that have emerged from this analysis paint a picture of the life world of occupational therapists. While all of them experience certain satisfactions and challenges, what occupational therapy means varies for each of them. Each individual is also a mix of reactions. Daily struggles and coping strategies vary : they arise in different contexts and at different times. To one therapist, 'caring' can mean being intimately involved; to another, or to the same therapist on another occasion, it may mean maintaining an efficient distance. 'Good' occupational therapy might at times mean a holistic focus using intuition and working creatively within activities. But in other situations, a therapist might prize being more technical and scientific. Relationships with the treatment team may be viewed as collaborative or threatening, and not uncommonly as both. The danger, as we seek to define the occupational therapist's life world, lies in over-generalising.

A number of arguments in fact can be mustered to question the very possibility of specifying a life world :

- 1) Patterns are not predictable and they vary from individual to individual. For instance, the therapists each have a different view of what 'holism' means. Even within each individual, life world patterns are not straightforward. The same individual invariably carries multiple meanings and experiences; as we have already seen, there exist very different understandings of what 'care' means.
- 2) The multiple and contradictory meanings within each theme (such as views of occupational therapy) makes it difficult to relate to just one life world.
- 3) The very diversity of practice experienced by different types of therapists (for example, be they hospital/community therapists or experts/novices) raises doubts as to whether a life world can be extended to other contexts.



- 4) Understandings shift, relationships evolve and people move on as they gain experience. Such change over time raises the question of whether any description of a life world can be generalised to other time frames.
- 5) Arguably, the general features of the life world that have been identified are so general they apply equally to other health professionals. Certainly much of the wider health care literature contains material equally relevant to different professional groups. Does it make sense to specify a separate occupational therapy world?

Taking such questions on board, we need to recognise that *if* the life world exists, it is made up of a myriad of interpenetrating meanings - the inner core of which changes in the context of other meanings. In other words, it is made up of contradictory, ambiguous meanings and takes place in a dynamic, social context. In accepting this fluid nature of a life world, is it still possible for us to specify one?

One argument is that several different occupational therapy life worlds exist. Occupational therapists practising in the same general areas share a common experience not reached by others. Thus, the community occupational therapists all share a 'community experience' and they operate in different ways from hospital therapists. Similarly, the physical occupational therapists retain a clear link with each other across hospital-community boundaries and do not have such a link with mental health occupational therapists.

If we accept these points of commonality and difference, we could go on to argue that occupational therapists share a life world with other health care professionals working in their same area. Community occupational therapists, it could be argued, may well identify more with other community practitioners than with non-community



occupational therapists. Physical occupational therapists may feel they have more in common with physiotherapists, while mental health occupational therapists may feel more of a bond with other mental health workers. None of this is surprising given that the life world emerges out of a specific social context and is influenced by broader social relations. It is formed through the activities and relationships of that space in time; individual meanings are negotiated within a social context.

But it is also possible to argue there is a *unique* occupational therapy existence. There is something specifically 'OT-ish' about the occupational therapy identity.

Occupational therapists are special because they : i) agonise over their role; ii) believe in a unique holistic, philosophical value base; iii) take pleasure in their 'craft'; iv) are client-driven and seek the client's active participation.

Looking at each of these characteristics in turn, firstly, there is this sense of the occupational therapists continually agonising over and debating their role : they wonder who they are. Their degree of defensiveness in the face of ignorance about their role and negative stereotyping is perhaps unique to occupational therapy. Some health care practitioners in 'new' contexts (such as community mental health) may share some of these uncertainties and the tensions that come with role blurring. The difference is that all occupational therapists seem to feel this uncertainty to a greater or lesser extent. Where they differ is how they act on it. Some may trade off ambiguity for certainty via a reductionist focus on activities of daily living; others may adopt another skill or qualification such as counselling.

Secondly, while rejecting occupational therapy, therapists simultaneously embrace it. They are proud of their profession. They share a belief in its holistic values and they value its philosophical base. Ultimately, they believe, occupational therapy works and



they like the focus on everyday 'doing'. Whilst other professions pay lip service to holism, occupational therapists' dual training and professional values ensure that holism is central and a continuing preoccupation.

Thirdly, the occupational therapists all seem to enjoy occupational therapy. They relish the craft. They take pleasure in the 'art' of using themselves as treatment tools. They get a 'buzz' from doing occupational therapy type activities. They are stimulated by the teaching-learning-enabling process. Most of all, they value the sense of collaboration.

Whilst all professions may seek to 'make a difference', the form this takes for each profession probably differs.

Finally, whilst all the health professions probably share the aim of enabling patient participation (Ashworth 1997), what this actually means varies. For occupational therapists there is a special sense of participation. In a real sense, the patient/client must be actively involved and doing. If the patient/client is not prepared to be involved then occupational therapists cannot offer treatment. Further the patient/client collaborates in treatment, actively making choices. They take control of their doing. The occupational therapists enter into therapy without prescriptions or answers. In this sense they are client-driven, not problem-driven, and their work remains unpredictable. The very things which frustrate the occupational therapist - the diversity, openness and ambiguity of practice - are also the things they celebrate.

My research leads me to suggest that occupational therapists share an identity and so do indeed share a life world. Though the boundaries of this life world are fuzzy, dynamic and open to negotiation, it is made up of shared meanings of what it is to be an occupational therapist. It is also made up of multiple, intersecting life worlds as



occupational therapists share other features of their life world (namely in terms of relationships and temporal/spatial dimensions) with other health professionals.

#### **5.2.4 The socially constructed therapist?**

The argument that the therapists share a life world with others suggests the broader social context has significance. The exact nature and degree of this significance is open to debate. In phenomenological terms, the subject is seen to reveal itself in and through its social context (referred to in the literature as the 'outer horizon of meaning'). Engaging with the social world opens up different opportunities to see action of a particular kind is required, but the therapists themselves decide how to construct this. An alternative interpretation comes from the social constructionist perspective, which would deny the extent of this autonomy. Social constructionists view the social environment as moulding individual therapists in different ways (Wetherell and Maybin 1996). As Hall (1996) puts it : "Identities are never unified...never singular but multiply constructed across different, often intersecting and antagonistic discourses, practices and positions" (1996, p.4). Whilst it is beyond the scope of this thesis to resolve this debate, it is possible to identify points where research has revealed the dynamic relationship between personal and professional and shown how this is set within a broader health care arena.

To examine this social influence, four aspects of the therapists' world will be considered briefly: i. the relationship with patients/clients ii. the therapists' use of social evaluations; iii. the role of professional socialisation; iv. the relevance of ideology.



The therapists' relationship with patients/clients sharply demonstrates the interaction between the individual and social. Each therapist must handle the tension between personal needs and the demands of the social context. For instance, Jane admits to her clients being her 'family', the children she does not have. She seeks a deep, personal, mutual, caring relationship with her clients. Yet she is also a professional. Her training and experience have taught her she must keep a distance. She therefore incorporates a distancing strategic element in her interactions, and works at being steady, not showing too much emotion (i.e. she always presents as calm and nice). Jenny, for her part, negotiates various transferences with her patients. At the same time she is careful to remember the dangers of involvement; after all, she must face the risks attendant on working in a forensic unit with patients who have violent histories. Phenomenologists would see these dynamics as part of the process of engaging in the life world of relationships. Social constructionists would focus on how relationships are negotiated in specific contexts.

The therapists' use of social evaluations about their patients/clients also reveals complex personal-social dynamics. Firstly, the therapists come into their relationships loaded with personal needs and prejudices; Peter, for example, admits to liking older patients from certain areas of town as they remind him of his grandmother. But on top of this, the relationship between therapist and patient itself will have a bearing. The patient/client is not a passive recipient of labels; indeed, he or she might actively invite them. In other words, labels are negotiated. Therapists can also be influenced by their professional socialisation and the values of the treatment team about the kinds of categories that are acceptable. The wider health care context is also relevant; therapists' evaluations of certain patients/clients may relate to how much the latter ease or increase work load. Further, the routinization of care can be seen in terms of a



broader process of bureaucratisation which exerts control over both staff and patients (Jones 1994). For phenomenologists, the therapist life world is made up of interpenetrating meanings which shift in the context of others' meanings. For social constructionists, the therapists' evaluations arise through dominant cultural discourses and practices.

A third illustration of the impact of social processes is the role played by professional socialisation. The research showed that all the therapists had been influenced by their early professional training - training which seemed important to all of them and played a key role in shaping their ideas. Whilst the therapists might have entered training predisposed to a particular way of thinking, their ideas will have been further shaped by their studies. Whilst phenomenologically this can be understood as the therapists' past learnings giving their present and future identity meaning, social constructionists would argue that they have internalised professional discourses.

Finally, there is the role played by ideology, more specifically that pertaining to the 'free market'. The impact of this ideology can be seen in different ways. In the market-driven economic realities of the 1990's, therapists are under pressure to treat more patients, which in turn results in more superficial contacts. Competition for jobs exacerbates tensions within the team. And in a context preoccupied with 'outcomes', therapists are propelled towards measurable quantifiable therapeutic activities (like activities of daily living) rather than qualitative, holistic care. Phenomenologists would argue that the therapists are actively and creatively constructing new meanings within a changing world. Social constructionists would understand the therapists as having been constructed by this changing world.



### 5.3 METHODOLOGICAL EVALUATION

In grasping the intelligibility of...lived experience, phenomenology helps us to understand something about ourselves, our possibilities and our limitations. (Kestenbaum 1982, cited in Morrison 1994, p.20)

My research has focused on a little explored area; it has offered a glimpse into the life world of twelve occupational therapists. Whilst the phenomenological approach adopted has captured much of the way they experience their daily work and their feelings and attitudes (both positive and negative), the study also has its limitations. This section evaluates the strengths and limitations of the research in terms of: the findings; the methods employed; and the methodology as a whole.

#### **Critique of findings**

A major strength of this research project is the rich descriptions it offers of occupational therapists' meanings, providing an insight into their existence. The therapists' voices, directly quoted, lend authenticity, even if they are to be interpreted as indicators rather than as hard evidence. An attempt has been made to present the findings in a clear, coherent manner which strikes a balance between analysis and quotations.

My research documents some complex psychological processes of individual therapists who are experiencing role ambiguity in a time of change. It indicates that therapists operate simultaneously in both holistic and reductionist modes and it shows how this is enacted in a broader context of 'coping'.



None of these findings have come as a surprise, although their precise nature and degree of expression could not have been predicted. They are consistent both with the literature in the field and with my own experience as a therapist. Had the work thrown up any startling new findings, these may well have had questionable status. The non-surprising nature of my findings is reassuring. As Van Manen (1990) notes, "a good phenomenological description is something that we can nod to, recognising it as an experience that we have had or could have had" (cited in Morrison 1994 p.22).

At the same time, my research departs to some degree from the literature : for example, in the challenge it poses to simple assumptions about holism and caring. New insights are offered and the work adds to our current level of knowledge, besides presenting elements of a critique of the current literature.

The main, and unavoidable, limitation of my research is that it remains a selective, constructed account. It could be argued that my findings are too neat, that they mirror too closely the literature themes. I could also be challenged for censoring some of the more 'taboo' thoughts and interpretations, ensuring a result more palatable to the professional community. However, that I have engaged in 'self presentation' would seem to be inevitable. The integrity of what has been included is, surely, more important an issue than what has been omitted. Ultimately, there is no such thing as an interpretation-free, 'true' account. That I actively recognise my research to be a construction of the therapists' reports is, I would argue, a source of strength.

My research could also be criticised for insufficiently exploring more personal meanings located within the therapists' private, as opposed to public-professional, world. Female therapists' sense of their attractiveness (or otherwise) as women, for example, has not been explored - despite the fact that a sexual dimension was



undoubtedly present. Had I developed a longer term relationship with the therapists these aspects may be been revealed. The analysis as it stands remains, and can only be, a partial glimpse.

The research can also be challenged from positivist positions of validity and reliability. This study cannot be generalised to other occupational therapists, as my sample is clearly both unrepresentative and idiosyncratic. Secondly, the information obtained is entirely the product of the specified interpersonal context. Another researcher would have elicited different data and interpreted the findings a different way. Thirdly, the research was undoubtedly 'biased' by my own values, interests and experience, both in terms of the data collected and the interpretative analysis.

This work, however, is based on a rejection of the relevance of positivist conceptions of validity and reliability. Instead, I argue that I establish integrity by systematically justifying my claims in a transparent manner. Essentially, the trustworthiness of this research has been established by : a) reflexive introspection; b) documented evidence; and c) communicative validation.

### Reflexive introspection

The fact that I have engaged in (and have been able to engage in) continual and explicit reflexive introspection throughout my research can be seen to be a real strength. This personal dimension has value in three different ways. Firstly, my efforts to reflect critically and thoughtfully on all aspects of my methodology and findings enabled what I see as valuable insights. I argue that these insights about occupational therapists' life world are deeper than the unreflective perceptions of the therapists themselves, as I have both lived through, and reflected upon, the experience. Also, I have been able to



exploit the knowledge that comes from being an occupational therapist (an insider), thus contributing to the sense of 'pragmatic truth' (Kvale 1996).

Secondly, my systematic use of reflection provides a public log of my methodological assumptions and decisions. The way I have been prepared to reveal my 'flaws' or negative reactions and my attempt to be aware of defensive strategies further endorses the integrity of my findings.

Finally, the exploration of reflexivity as a method of research in its own right (in section 4.3) makes a useful contribution to the professional literature and promotes debate about new ways of conducting research.

### Documented evidence

I have systematically justified my claims by providing examples of the participants' behaviour and what they have said. By offering a full and transparent account of my reasoning, I have opened up the research to external audit. Readers can assure themselves that my interpretations have an anchor in what my participants said and did. Further, the use of the therapists' directly quoted voices has lent authenticity and richness to my findings.

In a different way, my analysis of the interviews and observation has been substantiated, to a degree, by the literature review where similar themes and preoccupations were evident. The fact that some rather different material emerged, however, is a positive, rather than contradictory, development. This demonstrates that I have tried to separate the analysis from the literature, by bracketing preconceptions in an effort to respond to the data itself.



### Communicative validation

I have tested out my findings through dialogue with my participants and with the wider academic and professional community.

With particular reference to participant validation, I asked Mary (interview 1) and Jane (participant observation 1) to read and comment on the analysis of their particular interview/observation. It was reassuring that both accepted my findings without reservation, observing that they were in fact a little embarrassed that I had been able to see so much. I was reassured my findings were not a creative fantasy or the arbitrary product of my presuppositions (Ashworth 1993). But I was also a little concerned at the lack of challenge and probed them both for some criticism. I interviewed Mary a second time, and pursued matters informally with Jane. Even then, neither questioned or criticised my findings.

I chose not to engage in any further participant validation as it did not seem to have proved a particularly useful path. I felt there were a number arguments against participant validation which justified my decision not to use this method. Both Mary and Jane tended to see me as the 'expert' (on them!). I felt uncomfortable with this role and did not like the implicit connotation of unequal power. It could be that the participants were unable to look critically at the material. Or it could be that they were trying to please me and were unwilling to voice disagreement. Another possibility was that the participants might not be sufficiently aware of their meanings to give a critical reaction. For instance, they might not have access to unconscious motivations and as they would be viewing their actions retrospectively, they might not remember their intentions at the time the actions took place. It should also be remembered that it is in



the interests of the participants to protect their 'socially presented selves' (Ashworth 1993).

However justified, the limited extent to which I involved the participants in co-operative inquiry is open to criticism. Arguably my research could have been enriched further had I co-opted the participants as co-analysts and engaged them in a more reflexive dialogue (Smith 1994). Had my methodology been more 'political' in the sense of aiming to empower (as per feminist methodology), I would have made more use of participant validation and engaged in much more sharing throughout.

In terms of testing out my findings with the academic and professional community, my supervisors provided a first line of validation as they offered both positive comment and criticism throughout the research process. Then, through my published articles and conference presentations, I have laid my findings open to the wider occupational therapy community. It has been reassuring to receive a strong degree of support and acceptance from these therapists. They have responded positively to the idea that I am 'holding up a professional mirror'. In turn, evidence from discussions at conferences suggests therapists have begun to build on my research. My research may well have long term value as therapists use the opportunity to examine their identity and perhaps even change their professional trajectory.



## Critique of methods

My primary research methods - interview and participant observation - have their own strengths and limitations.

### Interview

The use of interview as a research method has proved to be extremely valuable. It allowed me to access the participants' meanings in a way other methods would not have done. Over the course of the interview the participant and I could explore key points and I had the opportunity to check out and clarify my understandings. Further, we had the time to build up rapport and trust. The fact that several of the participants felt safe enough to cry in front of me attests to this.

Importantly, the interview format (being relatively non-directive) allowed the participants to focus on what *they* saw was important. As a result, their narratives powerfully expressed their feelings.

However, a number of criticisms can be levelled against interviewing as a method. Firstly, the interview is a static process. The participants are stuck in their chairs rather than moving and acting in their world. This focus neglects the person's embeddedness in social contexts. For this reason, the informal interviewing which took place during the participant observation carried extra value.

A second problem with interviews is the primacy given to verbal aspects. The interview transcripts are seen to mean more than bodily expressions and the interpersonal dynamics of the interview itself. Although my reflections and reflexive



analysis attempted to grapple with these dimensions, they remained marginalised. This suggests that my findings may well have missed out some crucial details.

Thirdly, participants can always 'lie', dissemble or not quite reflect their reality. Clearly they are engaged in an exercise of self-presentation. However, on this point I choose to believe that the participants were saying what they were experiencing in the context of socially acceptable discourses (such as 'being a normal therapist') and conclude that this is the data I want to work with.

A number of criticisms can also be made of the way I carried out the interviews :

- 1) My interview technique often fell far short of the ideal. I would often catch myself asking multiple or ambiguous questions. Further, I was not as non-directive as I would have liked to be : for instance, on a couple of occasions I pushed for responses on 'good'/'bad' patients. As a result, I may have unintentionally led the participants down roads of my own choosing. On the positive side I tried to engage in conscientious reflexive analysis in an effort to acknowledge and investigate the impact of such responses.
- 2) More critically, my comparative inexperience with phenomenological interviewing meant that it took several interviews before I became comfortable with asking questions about concrete, everyday activities. It should be remembered here that the intuitive components of therapists' practice are not easily verbalised : for instance, it is easier to talk in the abstract about 'roles' than about 'being'. The outcome of all this was that I received a large amount of data which was cognitive in nature. The therapists were inclined to intellectualise rather than focus on their actual experience of doing.



3) I also have to recognise the limitations inherent in conducting just one interview.

The information gleaned may be relatively superficial or even trivial. I can also be accused of seriously interpreting the responses on the basis of comparatively little evidence. Was an hour or two enough time to build up any sort of rapport or trust with each participant? I remain aware that had I undertaken more interviews with each participant I might well have got a different story. However, what would the status of that account be? Would it be a 'truer' story - or just a different one?

### Participant observation

By way of contrast, the participant observation proved enormously valuable in that it gave me a 'feel' for physical occupational therapy work. My last contact with physical practice had been in 1977 when I was on fieldwork experience. Through participant observation, I could check out the degree to which the therapists actually did what they said they did. I could also follow a chronology of events and observe how accumulated activity over a week was experienced (for instance, the pace and build-up of stress over the week). The naturalness of the research setting did much to compensate for the pressures of 'reactivity effects' where the participants were clearly inhibited by my observation and on their best behaviour. Despite the presence of reactivity effects, I believe I saw some reasonably ordinary, everyday experiences.

The following extract from my reflective diary lends weight to this claim :

*For a week I lived the experience of commuting, wearing a uniform and working an 8:00 to 4:00 day. I have joined in the daily routines and have got a 'feel' for what it would be like to work there. As always, being in hospital was a powerful experience. The emotional assault of witnessing the patients' pain aroused my personal empathy and my professional instincts. I identified with the therapists. In a way it was a much richer experience than simply*



*interviewing the therapists - particularly since I was doing a fair amount of discrete interviewing as well. My immersion in the setting helped me to empathise better and get emotionally involved.*

However, the participant observation method employed in my research also has several limitations :

- 1) It can be questioned whether the sample times I observed were representative and typical. Jane, for example, admitted that she had deliberately 'stage managed' some of the referrals.
- 2) My observations inevitably remain partial and selective and my inferences are subject to charges of bias. I tended to view the therapists' work through my 'mental health' eyes rather than from their perspective. Some of the data I recorded must be open to question, as often I was unable to take notes on what I heard or saw immediately. Thus many of my records are retrospective constructions.
- 3) Many of my observations were of routine, almost superficial, behaviours which did little to allow me into the therapists' inner worlds. This is a central problem for observation as a method. It was for this reason that I supplemented my observations with constant, informal 'interviews'.



## Critique of Methodology

The strengths of phenomenological methodology as a whole have already been discussed in section 2 of this thesis. Whilst I can justify the use of my methods, I remain aware of their limitations and how they might be critiqued from both within the phenomenological perspective and from outside. This section discusses some of the critical arguments.

### Criticisms from within the phenomenological perspective

Some phenomenological theorists might justifiably consider my understanding of phenomenological philosophy to be patchy. I have worked to develop my understanding and have also studied critiques of research in nursing in an effort to avoid those pitfalls. But in the end I cannot say for certain that I have more than a partial view.

Some philosophically inclined phenomenologists would question the way I have used reflexivity and my approach to reflections and subjectivity. They would challenge the implicit assumption that the 'subject' can exist in a separate form from the 'object'. Is it possible to separate what we perceive from who we are? Some philosophers, such as Heidegger, even challenge the notion that there is an independent reality and that phenomena can be described in the first place. A straightforward answer here would be to disagree and point to the 'real' physical/material base of social relations. Further, I would suggest that whilst it may be difficult to separate the subject from the object, we can still explore the nature of our interpretations. If life worlds are shared it should be possible, with introspection, to begin to unravel different meanings and



understandings. In my view this suggests an essential role for reflexivity. Ideally, reflexive analysis needs to recognise the socially constructed nature of the world we inhabit and acknowledge that any description of a phenomenon remains a tentative interpretation - not an accurate description of some clearly defined object - leaving aside the question of whether or not it is 'real'.

My specific phenomenological method might also be criticised for not quite capturing the life world. It was perhaps too easy for me to retreat into describing feelings/attitudes which remained 'outsider-therapist' interpretations rather than 'insider-empathy' understandings. Others, too, might find fault with my 'invented' and personalised way of analysing and presenting the data.

My principal line of defence is that I have managed to capture something of meanings and have conscientiously related these to the literature review. This would seem to be more relevant than whether or not I could have done it differently or better. Further, I believe I have managed to capture a few really expressive phenomenological moments, such as Jane being 'in love' with her car, Jenny being stalked by her 'creepy' patient, and Mary being 'sucked dry' or experiencing a 'tear' in her connectedness with the team. I am aware these understandings can be criticised as being interpretations.

However they are not interpretations in the sense that they attribute causal explanations; nor are they attempts to offer psychodynamic understandings of unconscious motivations. Instead, the interpretations are a playful, poetic attempt to capture certain experiences.



### Criticisms from outside the phenomenological perspective

Critics speaking from outside the phenomenological perspective would undoubtedly question the epistemological and ontological assumptions, and the methodological choices, made. They might disagree with the relativist assumptions offered, preferring more realist positions (Wetherell and Stills 1996). They may challenge the idea that anything meaningful can be obtained from research interaction with just a few individuals. They could question whether a 'life world' can be described. They might dissent from the views that it is possible to articulate meanings and they might question whether subjective interpretation is either necessary or important.

Positivists would challenge the whole subjectivity of my research on the grounds of 'undue bias'. The data gathered, and the subsequent analysis would be seen by them as reflecting my personal preferences rather than any objective standpoint. My claims to validity would, in their view, stand debunked.

Several arguments can be put forward to answer these criticisms. To begin with, one can turn the tables on the positivists by arguing that unacknowledged bias may entirely invalidate research results. Phenomenologists and social constructionists recognise the relative, multiple and socially constructed nature of reality; they understand that meanings are negotiated in particular contexts (Denzin and Lincoln 1994, Wetherell and Maybin 1996). When interaction with participants in research has a decisive impact on the results, dynamics involved merit careful attention. The "challenge is not to eliminate "bias" to be more neutral, but to use it as a focus for more intense insight" (Frank 1997, p.89).



Moreover, the very concept of 'bias' can be contested as it assumes an unequivocal reality which is somehow distorted by subjective interpretation. If multiple interpretations of the same event are possible, it follows that we must positively embrace subjectivity rather than dismiss it as 'bias'.

Critical social researchers (for instance, of Marxist or emancipatory theoretical persuasions) would challenge the post-modernist assumption underlying my research that different subjective interpretations are equally valid; that they are simply different 'voices'. Are all meanings relative? Surely some accounts are more authentic or more powerful than others? Critical theorists would object to my lack of attention to the power dimension and the influence of ideology.

One response is to agree that some voices and stories are more 'real' than others; for instance, some stories are more trustworthy or have been thought through more deeply. However, it is still important not to lose sight of the point that multiple interpretations are always possible. This then provides a justification for the need to do some additional probing through reflexive analysis. Further, the process of reflexive analysis can undermine any tendency towards subjective arrogance or belief that one's own view has to be right. We need to remain humble about the tentative, emergent quality of all our interpretations.

Significant challenges could come from social constructionists who would criticise my research for being unduly focused on the individual rather than on social dimensions.

Several strands of argument are relevant here : a) They would argue against the notion of individuals as agents of their own actions who attach personal meanings to their experiences. Instead, they would argue that individuals are socially constructed :



that individuals cannot be detached from their social context. Arguably my research has paid insufficient attention to the micro- and macro-social processes influencing the participants. b) Social constructionists would take issue with the alinguistic approach taken. Although my methods have drawn heavily on language (interview texts) I have not attended to the linguistic components, nor adequately recognised the nature of socially embedded discourse. c) Social constructionists (along with others) would challenge the value of my focus on description as opposed to explanation. They would argue the importance of looking at the wider social-political-economic context in shaping the therapists' accounts. Privileging the 'personal' can be seen as missing the point that the individual is the "sum and swarm of participations in social life" (Bruner 1990, cited in Wetherell and Maybin 1996, p.223).

Psychodynamic researchers would value the subjective focus of my research and the introspective methods employed. However, they would view the findings as representing only a partial understanding as unconscious elements have not been explored.

These different perspectives would all offer their own specific insights - each with their own strengths and weaknesses. Taking a relativist position means acknowledging any research will always be contextual and dependent on perspective, but Wetherell and Stills (1996) argue that taking such a position does not prevent us from making assertions and arguing for certain values over others. They justify this by arguing that if knowledge and truth are seen as human constructions there is even greater need to argue and defend one's position.

I have defended my research by recognising its contingent, constructed qualities whilst being pragmatic about judging any claims to validity.



## 5.4 REFLECTIONS ON THE RELEVANCE AND IMPLICATIONS OF MY RESEARCH

My research examines *how it is*, positive and negative, for a handful of therapists. It makes no claims about what occupational therapy has been , could be or should be. It attempts simply to describe current practice in Britain, to capture a sense of what is happening to therapists now, in their own particular 'real world'.

The snapshot offered has thrown up some interesting questions about how occupational therapy is changing. The amount of one-to-one work (as opposed to group work) practised is striking, as is the degree to which activity has been marginalised. I had not expected quite so clear a pattern. Therapists' lack of awareness of theory and confusion about role also surprised me somewhat. These findings suggest occupational therapy is changing. I wonder to what extent the content of occupational therapy training courses actually reflects these changes?

This section picks up some of these debates within the profession. I reflect on a number of issues about occupational therapy practice and consider some implications for professional education. A final section suggests some areas for future professional research and argues for a shift in focus.

### On role angst

The degree of angst and confusion has begun to trigger in me a sense of fatigue.

Lacking professional esteem, therapists seek other avenues and skills to make good the absence. The end result is a further watering-down of what occupational therapists do,



leading to even more confusion and dissatisfaction. Occupational therapists do not need to wallow in this negative cycle of feelings.

My research suggests there might be some other options :

- 1) Instead of wallowing in uncertainty we should aim to be clearer in our own minds.

We can talk about occupation and participation as core ideas for the profession; we can also talk about life-style management or focus on occupational roles.

- 2) We should accept - no, value - the breadth, diversity and ambiguity of our work.

We need to recognise this arises in part from being client- (as opposed to problem-) driven.

- 3) We should stop making simplistic claims about occupational therapy, in particular

that it is unique and special because it is holistic. We do not understand this sufficiently and there may be destructive implications if we persist with it. In any case, it sounds both arrogant and naive. It would, I believe, be far more constructive to focus on developing a holistic approach within the team.

## **On the care-power relationship**

My research has revealed some of the complexities of the therapist-patient relationship - in particular how power is embedded within caring. Perhaps my research will redress some of the imbalance in the rhetoric and will correct claims that our relationships are always caring and based on mutual collaboration.

A key finding of this study is that both caring and power carry multiple meanings.

Future research (and teaching on this subject) should explore this further. In particular



I would like to see more investigation of the complex nature and different levels of power : what it means, and the different ways it is enacted. Acknowledging that power is relevant would make a good start.

I am pleased to report that my research has also challenged some professional taboos.

I have apparently said some unsayable things : for example, that patients can be 'creepy', or 'bad', or they that they 'suck you dry'. I have also raised the spectre of a sexual dimension between therapists and patients. I know from feedback I have received on my articles and conference presentations that I am upsetting some people; my position, however, is that such sensibilities need to be challenged.

### **On work pressure**

Of special interest to me was to learn how much of the pressure of work comes from dealing with different team members as opposed to difficult patients/clients. The conflict, competition, power and hierarchy issues have come through strongly. In fact, the idea that the dualist care-power relationship with patients is being similarly enacted in relationships with staff is a particularly interesting insight.

That work pressures can be understood as arising from broader social-economic-political dimensions is also important. It is clear that changes in the structure of health care (such as marketisation) have done much to increase the pressure on practitioners. Yet it is also clear that, as a profession, we tend to lack political awareness, typically locating problems/pressures at the micro-level of group dynamics rather than at the macro-level of social policy. Therapists currently see their jobs are under threat and their professional base is being eroded, but the point that this is reflected in, and even



spearheaded by, current policies, is not clear to them. I would like to see an enhanced macro-social level of analysis brought into education and research.

In terms of coping mechanisms I have been struck by how important supervision is for practitioners along with gaining special support from the occupational therapy team.

Whilst these ideas run counter to current political ideology, my research findings question the wisdom of dismantling professional structures too quickly - particularly on grounds of cost-effectiveness.

### **On the occupational therapy identity**

Throughout my research I have had an implicit question in mind : is occupational therapy one profession or are we different animals? This seems a fundamental question, particularly as we seek to justify our professional existence in the current climate. Whilst I am not able to produce a clear-cut answer to this question, I believe my research has a contribution to make.

- 1) My research has demonstrated that there are real differences between therapists working in different areas. It is important to recognise that these differences reach beyond the question of role. I believe that by offering a phenomenological analysis I have captured a deeper, qualitative dimension.
- 2) I have suggested that occupational therapists have close links to other health care professionals and that we perhaps share a life world - a point that tends to get lost in the midst of inter-professional squabbles.



- 3) I believe I have also demonstrated that it is possible to capture something that is uniquely an occupational therapy identity and that this identity somehow crosses all the borders and diversity of practice.

### **On physical practice**

The profound split between physical and psycho-social occupational therapists has emerged quite strongly. I am not surprised. I also have to admit to feeling uncomfortable with aspects of acute physical practice - aspects which seem far removed from the central tenets of occupational therapy. This is, of course, a controversial area. I do not think an emphasis on independence (namely, in personal care activities) should be the *raison d'être* of occupational therapy. Others would disagree with me. This is a professional debate that will continue.

I think my research contributes to this debate by highlighting that physical occupational therapists find much of their reductionist, 'assembly line' practice deeply unsatisfying. Other research on holism has acknowledged the retreat into mechanical practice and the difficulties of applying holistic care in the current climate. Maybe it is time to start looking at what we should do about this. One option would be for occupational therapists to withdraw altogether from the acute, hospital sector.

### **On implications for education and professional socialisation**

My research carries certain implications for occupational therapy education. In particular, some of the occupational therapists' responses suggest they may not have



been quite as well prepared for the 'real world' as they might have been. This raises such questions as :

- Are students sufficiently prepared to cope with the 'assault' of pressure, conflict and being devalued by others? I see a need for occupational therapy colleges to teach 'coping strategies'. Students would gain from hearing about what strategies (both conscious/unconscious and positive/negative) practitioners use.
- Are students prepared sufficiently to cope with the contradictions between occupational therapy ideology and practice? For instance, the rhetoric of holism is well aired and leads some to reject the medical model and the use of diagnosis. Yet the reality is that the medical model is still used. As a result, practitioners are faced with a dissonance. Some end up feeling they have failed in not meeting the impossibly high standards of 'ideal' occupational therapy.
- To what extent do students leave college with idealised images of occupational therapists as heroes? The reality of practice is that the therapist may often play only a small part in treatments. Graduates are likely to be quite shocked when they first encounter this idea. In the confusion one response is to reject college teaching. But then what are they left with?

Idealism does not need to give way to cynicism in professional socialisation. I believe a different process operates, namely that cynicism results from too much idealism. Themes of complexity and challenge should be the starting point, not impossible ideals. For instance, in teaching the occupational therapy role, I believe it is unhelpful to teach idealised versions of what the occupational therapist could do. Instead, the different



choices and constraints need to be explored. Rather than students being taught to be 'non-judgemental' of patients/clients, they need to recognise social evaluation is unavoidable. The message to stress is the need to separate the benign evaluations from the pernicious.

## **On implications for professional research**

I believe my research makes a contribution to the growing pool of qualitative research relating to psychology and health care. Firstly, it contributes to the corpus of detailed studies of individuals, a corpus which is enriching current thinking and theory development. For instance, my research offers an account of how therapists simultaneously operate in holistic and reductionist modes and how this is negotiated in a context of 'coping'.

Secondly, my specific use of phenomenological analysis contributes to the qualitative research base within the health professional literature. Whilst this approach is still regarded with a degree of suspicion (and on occasion dismissed) by health psychologists, the insights it offers are beginning to be valued. Dominant positivist discourses are beginning to be challenged in what I believe to be a beneficial way.

More significantly perhaps, I believe my research, in particular my use of reflections and reflexivity, suggests new ways of conducting research. My commitment to analysis of a more personal nature has carried some risks; some might say my approach has been too radical, in the process losing legitimacy and credibility. But, as I see it, reflexive analysis has been a key strength of the research.



At the very least, my research raises questions about epistemology and the nature of research inquiry. It will, I hope, fuel further debate.

## **On further research**

Not surprisingly, my research has raised more questions than it has provided answers.

There are a number of avenues that might be taken in future research. I can suggest seven particular angles that might be fruitful to follow up :

1. This research has begun to explore the experience of being an occupational therapist. Clearly much more work needs to be done to develop, validate or refute these findings. In particular, more qualitative and phenomenological research would seem to be called for - research which is broader than the current preoccupation with clinical reasoning.
2. It would be invaluable to be able to draw on research on more positive dimensions of practice - in particular research defining the 'craft' of occupational therapy. I would like to see more focus on those moments when occupational therapy works, when healing occurs, when suddenly some important shift takes place. We have all experienced it. It is what sustains us. But the concrete examples from experience are hard to come by. A phenomenological study looking at significant moments of therapy would certainly be fruitful.
3. I would also like to see more research into the coping mechanisms therapists employ. It seems to me that our need is less for research on stress and burn-out than for guidance about what to do about it. Qualitative research, along the lines of



Menzies Lyth's (1988) work in nursing and the different strategies adopted, both conscious and unconscious, would be valuable.

4. More research (both qualitative and quantitative) on British occupational therapy practice is essential. We currently draw heavily on North American and Australian literature and assume much of it is relevant. With more UK-based research we can begin to make some critical cross-cultural comparisons. In the context of globalization, there is clearly a need to develop an international perspective on our profession.
5. I would like to see greater use made of reflexive analysis, which should be developed as a research method in its own right. Further research in this area should engage the research participants more actively in a reflexive dialogue and involve them more as co-analysts.
6. Although my research has focused on phenomenological understandings, it would be possible to re-analyse the same data utilising a social constructionist approach and adopting discourse analysis as a method. A comparison of the commonalities and divergences of the two theoretical perspectives would provide an interesting analysis.
7. Finally, perhaps the most valuable work of all would be to look at occupational therapy from the perspective of the service user. While survey literature on what patients/clients think about occupational therapy is already available now, I would like to see it develop in phenomenological directions which explore their experience of occupational therapy at a deeper level.



## **6. CONCLUSION**

This thesis has explored the life world of twelve occupational therapists. An interpretivist, phenomenological methodology, drawing on data from interviews, participant observation and personal reflection, was employed in an attempt to capture what it means to be an occupational therapist. This conclusion aims to summarise the key findings which emerged and to highlight the value and relevance of this research.

### **6.1 THE LIFE WORLD OF THE OCCUPATIONAL THERAPIST**

#### **A brief summary**

The occupational therapists' sense of professional identity is confused and they feel ambivalent about their ambiguous profession. They are proud of and value what they do, but at the same time they may also reject the occupational therapy role and seek to embrace other more prestigious roles. They feel misunderstood and undervalued as they internalise the dismissiveness shown towards them by others. This, in turn, attacks their sense of professional esteem.

Occupational therapists are engaged in a desperate search to define who and what occupational therapy is. They confront the disjuncture of images arising out of



past understandings and beliefs about present and future obligations. The therapists manoeuvre to hold onto their holistic professional values in a work context which pushes them into more reductionist modes of practice, resulting in feelings of frustration and guilt which need to be managed.

The therapists attempt to demarcate role boundaries in the face of contradictory demands, external constraints and competition from other team members. The task is made more difficult in a changing health care context where they grapple with threats to their professional survival. This uncertain future contributes to anxiety in the present as therapists struggle to affirm their existence.

The therapists are engaged in an honourable mission to make a difference and help others. They are committed to their holistic, person-centred values and sustained by a belief in the ability of occupational therapy to promote health-enhancing change.

Whilst they feel frustrated about perceptions of their role, what they actually do gives them much satisfaction, particularly the process of enabling change in others. When the therapists succeed, they are thrilled and they feel effective and valued. Where patients/clients do not progress, work is experienced as dissatisfying and frustrating and the therapists internalise messages that they have failed.

The therapists enjoy the collaboration, creativity and active participation involved in their work. They enact their craft using themselves as tools in treatment and harnessing the therapeutic potential of activity. They engage in both phenomenological and scientific modes of problem-solving as they construct narratives about their patients'/clients' past coping and present and future needs.



The varied and dynamic relationships with patients and clients are seen as being centrally important both in and for therapy. Sometimes the therapists engage in relatively short-term task-orientated relationships where care is demonstrated through practical or technical assistance. At other times the therapists become intensely and emotionally involved in long-term rehabilitation of their patients/clients. They struggle to fulfil personal and professional needs as they negotiate degrees of involvement, enmeshment and detachment. Their relationships are multi-layered as dimensions of care and power interact in different, sometimes contradictory, ways. Whilst the therapists feel warm concern for their patients/clients, they also experience negative, angry feelings which have to be strategically managed. They control and direct, but they also strive to empower and engage in more equal collaborative relationships.

This care-power dimension is also enacted within their team relationships. The team plays a powerful role in the therapists' life world as a source of identity, meaning, and mutual esteem. It also provides structure to the working day. The team offers a safe haven of mutually supportive, collaborative relationships where the therapists can be healed. Conversely, the team is also experienced as a competitive battleground where therapists struggle to be valued and respected. As they strive to carve out a clearer role with more status they get hurt by dismissive, disempowering interactions with other team members.

### **Meaning and motive in an uncertain world**

The findings suggest that therapists are motivated by their mission to enable change and by their professional caring values. They are also engaged in an 'identity project'.

They are motivated by their anxiety about their professional identity and future, and



this drives them to carve out for themselves territory which they believe might become valued. Chevalier picks up these points when he describes one motivation as the search for meaning : "It is our search for meaning, a perhaps never-ending process of defining ourselves professionally and the way we work with our clients" (1997, p.539).

Meanings are derived from their occupational therapy craft and their values of holism, independence in occupations, collaboration and mutual participation. Occupational therapists believe in what they do and in the possibilities and purposefulness of the therapeutic encounter. They try to create meaning for themselves and their patients/clients through doing, creativity and achievement. Their relationships sustain them emotionally and give them a sense of purpose.

The findings also reveal that each aspect of the therapists' world carries multiple, even contradictory, meanings. Although all the therapists share meanings and motives, they enact them in different ways. Caring to one therapist may mean remaining detached and practical, whereas to another it means becoming emotionally involved.

Relationships can be something to embrace or defend against. Holism to one therapist means being client-centred; to another it means attending to psycho-social dimensions. A demanding patient may be perceived as a good challenge to one therapist and as a drain to another. Even understandings of what occupational therapy is and should be varies between the therapists and in different situations.

Ultimately, all the therapists are engaged in a search to find themselves and to cope in an uncertain, demanding and changing health care context. At a broad level there is a need to define a professional role in the context of a changing professional identity and



training. Further, in the context of prevailing free market ideology, therapists have been challenged to demonstrate better cost-effectiveness. They live with intense pressures of too many demanding referrals and not enough time, of having to prove their worth in the face of threats of litigation and redundancy. In addition, the therapists' roles within the treatment team are continually evolving with the restructuring of health care, for instance the growth of community practice. Threats involving a loss of profession-specific support operate alongside new opportunities for collaboration.

Therapists are thus engaged in a struggle to cope, though how they do so varies. For example, in order to cope with the contradictions between social models of practice and the realities of operating in a medical model context, some therapists evolve split identities, operating simultaneously as a person-centred therapist and an efficient procedural technician. To cope with pressures to assure effectiveness, some therapists develop new skills and qualifications which offer opportunities to engage with more valued roles, whilst others engage the mission to promote occupational therapy.

### **A unique life world?**

To what extent is the life world described above unique to occupational therapists?

Might the findings be generalised to other health care professionals?

An analysis of the findings and the wider literature suggests there is something uniquely 'OT-ish' about the degree of role angst expressed. Also the occupational therapists seem to engage in particular forms of caring, clinical reasoning and therapy. However, occupational therapists also share a number of commonalities with other



health care professionals. They share common goals, offer a common service and work in the same teams where roles are increasingly blurred. They draw upon a similar history of experiences and treat the same patients/clients (who may respond to the professionals as a unit whose constituents are interchangeable).

All health care professionals seem to experience similar struggles within their many different relationships - with both patients/clients and team members. They all need to manage the intense emotional impact of these relationships, to negotiate the boundaries between intimacy and professional distance. In different ways, all health care professionals have to grapple with the difficulties of 'caring' and what this means in the context of instrumental and unequal power relations. Similarly, their relationships with team members are often ambivalent as colleagues are seen as both a support and threat. For all of them, the desire to engage in collaboration is constrained by a competitive, hierarchical context.

The life worlds of health professionals also intersect in terms of time and space as they all negotiate similar pressures arising from their social context. All the professionals currently confront demands to enact new roles and demonstrate their worth or face redundancy. All of them shoulder heavy workloads in a context of insufficient resources. Where professionals work in the same field (for example, in hospitals or in the mental health sector), they share much in terms of concerns and stresses. The occupational therapists may well identify with these colleagues more than with their own professional group with whom they may have less contact.

In these ways it can be argued that all health professionals have been 'socially constructed' by their social environment - namely their professional socialisation, the



demands of their relationships and the broader ideological context. All the professionals have to negotiate the multiple, even contradictory, discourses and practices occurring within broader health care context. As such, it is not surprising occupational therapists share this life world with others. But within this general experience, it is also necessary to recognise the multiplicity of experience as each professional struggles to find meaning and survive in his or her own way.

## **6.2 THE VALUE AND RELEVANCE OF THE RESEARCH**

This research is the first exploration of the life world of occupational therapists in the United Kingdom. As such it contributes to the growing corpus of phenomenological literature on professional practice. Although it offers only a partial glimpse, it stands as an in-depth, rich, personally engaged account of the experience of twelve therapists. It is hoped that subsequent research will develop, extend and challenge the research methods employed and the findings arrived at.

The value of this research can be seen in terms of : a) the understanding it has promoted; b) the challenge it presents to the existing literature; c) the implications it raises for education, practice and the profession; and d) the likely impact of the research method it has utilised.

### **Understanding promoted**

My research offers insight into what it is to be a therapist. It is a rich account of the complex psychological processes, motivations and meanings, of individual therapists.



The analysis gives voice to their particular needs, thoughts, concerns and perceptions. It documents the way individuals strive to cope with the stresses of their work, for example, their defensive practices.

The research also documents the general experience of occupational therapists as a professional group and their responses to an uncertain world in the context of current health care changes. The struggle therapists have with their role ambiguity, and how they have sought to carve out new territory and negotiate evolving team relationships are all described in depth.

Finally, the research promotes understanding of how different health care professional life worlds intersect - for instance, in the way they deal with problems of care and intimacy in the context of an essentially unequal power relationship.

### **Challenge to the current literature**

The research both confirms and challenges the current literature. It contributes to the pool of professional literature - in the case of occupational therapy, a relatively small pool. Its findings support much of the current occupational therapy research dealing with role uncertainty, holism versus reductionism, and whether or not there is a physical versus psycho-social split in the profession. My research is also in tune with current clinical reasoning material, in the way it confirms that occupational therapists reasoning is complex, involving blurred frames and multiple modes.

In terms of the wider professional literature, this research contributes to the growing body of evidence on the challenge posed to caring and care when professionals are



constrained and buffeted by a range of forces. The literature on power relationships, team work and collaboration is enriched by the personal accounts offered in this study.

At the same time, my research challenges certain aspects of the literature :

- i. Firstly, my findings suggest a much greater degree of **complexity and contradiction** in practice than is apparent in existing sanitised accounts of professional activity. My project shows how care and power are enacted simultaneously; how therapists both reject their profession and take pleasure in its potential and practice; and how holistic and reductionist modes operate alongside each other. Contradictions and ambiguity are alive throughout my research and I feel that these are not always adequately acknowledged elsewhere.
- ii. My research also **interrogates some of the assumptions** buried in the literature. My findings challenge professional rhetoric which asserts that therapists subscribe to holistic philosophies or that teamwork is necessarily always a good thing.
- iii. My research suggest that therapists experience a **greater intensity of feeling** in everyday practice than is sometimes allowed for in more 'distant' professional literature. Thus, my participants expressed a depth of love, grief, anger, and even hate in their responses towards their patients/clients. The ambivalence and range of these expressions remains relatively unexplored territory, although I hope I have begun the process of opening it up.
- iv. My research has recognised how therapists regularly violate a range of professional **norms and taboos** - a fact rarely acknowledged in the literature. For example, my findings reveal that therapists may engage in unethical practice and they do not



always perceive their patients or teams in positive terms. Such findings are sensitive; they challenge prevailing, comfortable assumptions within our profession and its literature.

## **Implications for education, practice and the profession**

Given the tentative, partial picture my research offers, I am hesitant to assert any clear implications for professional practice and education. However, early responses from the occupational therapy community suggests my research could have some longer term impact. Specifically, my research can be seen as empowering occupational therapists as it gives 'voice' to their experience. It can also be seen as a 'professional mirror' which invites therapists to examine their approach and discuss directions for change.

Regarding **professional education**, it might be suggested that teaching should reflect current uncertainties and realities rather than ideal visions and rhetoric. Students need to feel confident about their potential role and contribution, yet also be clear about points of role flexibility, overlap and ambiguity. My research indicates students could benefit from understanding some of the complexities involved in their working relationships. They should be helped to negotiate difficult boundaries to do with role, teamwork, care, control and detachment.

The research also indicates that while occupational therapists endorse professional rhetoric (e.g. holism), much of this is difficult to put into practice. It also appears that therapists' understanding of occupational therapy theory is patchy and there is a



theory-practice divide which needs to be addressed. This raises questions about both the nature and usability of current theory and the way it is taught or received. It may be that students are not learning the theory well enough or that the tutors are not teaching it in a sufficiently accessible way. Alternatively, it may mean the theory is simply not proving useful in practice.

At the level of **post-qualification education**, the research carries several implications for professional development. One message to emerge is how much the therapists value their (profession-specific) supervision sessions - indeed, how great is their need for a range of support systems. Professional development activities could usefully focus on the pressures of practice and how they might be managed. More specifically, attention needs to be paid to helping therapists to clarify their role and to affirm their sense of value and self-worth. Another message from the therapists is the importance of professional development activities to foster new skills, build knowledge and enhance qualifications.

Turning to the **implications for practice**, my research suggests therapists have many positive feelings about their actual clinical work. The 'buzz' of a powerful therapeutic encounter and the satisfaction obtained from enabling successful progress cannot be understated. In all the soul searching that takes place around 'role', therapists may need to be reminded of how meaningful their work can be.

In terms of everyday practice, I would like my research to provoke professional debate. I would like therapists to take up the finding that it is 'normal' for them to feel negative things about their patients and their occupational therapy practice. By legitimising such everyday experiences, therapists may feel empowered to



acknowledge these feelings in themselves. With more open discussion, therapists may be relieved of some feelings of guilt and a more productive examination of the issues may begin to take place.

At a broader level of practice, my research raises questions about occupational therapy as a single or unified profession. Whilst my findings support the idea there is an identifiable experience of being an occupational therapist, the splits within the profession have also been exposed. Specifically, the differences between physical versus psycho-social practice and hospital versus community work were marked. More discussion needs to take place in the profession to establish appropriate boundaries. Are the splits desirable? Are they inevitable? Does the profession need to re-examine what activities and practices should be prioritised? Do therapists need to relinquish some of their more reductionist roles in order to more fully embrace the occupational therapy values, or should these values change? These sensitive and weighty issues are likely to continue to tax the profession over the years to come.

Turning now to **implications for the profession**, my research has relevance to broader debates on current and future social policy regarding the place of professionals and the evolution of health care. Current political moves to dismantle professional structures and limit professional influence present a challenge to all the professions. The challenge to occupational therapists is particularly acute if they lack a clear vision of their role and value. In the context of increasing market driven health care, the problem becomes even more greater. There is a real danger that some professional groups will become marginalised. My research indicates that while occupational therapists are aware of these threats, they have a little appreciation of the wider political context and the need to be more politically active to ensure the survival of the



profession (assuming this is desirable). The profession, too, may need to present itself and the contribution it makes more effectively.

## **Impact of research method**

My research has critically explored the application of phenomenology and reflexivity as research methods. This exploration offers a point of debate, a possible model of research practice, and it suggests a way forward - a way that is relatively uncharted at present.

This research contributes to wider academic debates around epistemology and methodology. Specifically, it highlights the relevance of attempting to capture individuals' meanings and it shows how it might be possible to describe the richness, contradictions and complexities inherent in any life world.

It thus follows that this research could stand as a potential model. Of particular interest is its method of operationalising some phenomenological ideas. It indicates how to describe a life world and bracket presuppositions and prior understandings in order to attend actively to the participants' view. The analysis also provides a model of how to engage in a complex interpretative thematic and reflexive analysis.

Finally, in adopting an interpretative phenomenological approach I have demonstrated how my research involved a dynamic process in which outcomes emerged within the context of the research relationship. I have argued that access to the inner worlds of others is both dependent on, and complicated by, my own understandings and



interpretations. I have therefore explicitly engaged in an on-going, in-depth reflexive analysis - a technique which has not yet been well aired in the literature. I have also acknowledged the central role I played in the construction of the thesis by offering a reflections section at the end of each section. Arguably, it is this exploration of myself as a researcher (as well as an occupational therapist) which sets this research apart from studies which aspire to be 'scientific'.



## POSTSCRIPT

*Coming to the end of my thesis, I find myself in a completely different place from the one I originally thought would be my journey's end.*

*Through carrying out the research, with all its highs and lows, I have learned a great deal - about occupational therapy, about the research process and about myself.*

*Whilst I am in a different place to the one expected, I feel my decisions at each point along the way have been appropriate. I remain aware that there were other paths that may have been fruitful, but they will wait for another day. For this moment, I am content that I have managed to capture a sense of the occupational therapists' existence.*

*Now, looking back, I wonder whose life world has been described. It seems to me that, at least at some level, I have described my own. Paradoxically, the process of exploring my professional identity, has made me feel both closer to, and more distant from, the therapists I studied. Perhaps this was inevitable; perhaps too, it is enough that I have sought to give voice to my profession - even as I leave it to enter the academic world.*



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